Head Start Health Matters

Findings from the 2012–2013 Head Start Health Manager Descriptive Study for Regions I–XII

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Preface

The health services area is a major aspect of the comprehensive services provided by Head Start and Early Head Start (HS/EHS) programs. HS/EHS staff work with families, health care providers, and other community agencies and resources to help ensure that all children enrolled in their programs are up-to-date on a schedule of age-appropriate preventive and primary health care (i.e., medical care, including immunizations, dental care, and mental health care) with any necessary follow-up; have health insurance; receive health and developmental-related screenings; have access to mental health services as needed; and practice a wealth of health-promoting behaviors with children and families, including handwashing, toothbrushing, nutrition, physical activity, and safety. An array of health-related services is also made available to pregnant women.

At the same time, given the independence of local HS/EHS program operations, relatively little is known about how the health services area is managed in HS/EHS programs in terms of staffing, resources, training, and prioritization and implementation of health activities. The last national survey of the Head Start health services area was conducted in 1993–1995, prior to the implementation of Early Head Start. In addition, prior research efforts on the health services area have neither included large samples of Migrant and Seasonal Head Start (MSHS) programs nor American Indian and Alaska Native (AIAN) programs (also known as Region XI and Region XII programs, respectively).

To fill this knowledge gap, the Office of Planning, Research, and Evaluation within the Administration for Children and Families (U.S. Department of Health and Human Services) contracted with the RAND Corporation to conduct the Head Start Health Manager Descriptive Study. The overall purpose of the study is to provide a current snapshot of health-related activities and programming within HS/EHS programs, to better understand the context in which the health services area operates, and to identify the current needs of health managers and health staff as they work toward improving the health of HS/EHS children, families, and staff. The study is intended to provide information about services currently provided and the challenges that HS/EHS programs face.

To accomplish this objective, the study designed and fielded a short online survey for HS/EHS program directors and a more in-depth online survey of the HS/EHS health mangers to whom directors referred us. All directors of HS/EHS programs in operation during the 2012–2013 program year were invited to complete a survey, including AIAN and MSHS programs. In addition, we conducted semistructured interviews with a small number of health managers who completed the online survey and a small number of teachers, family service workers, and home visitors. The results of the online surveys and interviews are presented in this report.

This study will be of interest to HS/EHS administrators, health managers, teachers, and other staff who contribute to the health services area in Head Start, as well as policymakers at the federal, state, and local levels who are responsible for supporting the implementation of health services in Head Start. This report may also appeal to researchers, practitioners, and policymakers interested more generally in health needs and health services in early childhood.

This research was conducted in RAND Health. Additional information about RAND is available at www.rand.org.

Overview

The health services area is a major aspect of the comprehensive services provided by Head Start and Early Head Start (HS/EHS) programs. The Head Start Health Manager Descriptive Study was designed to improve our understanding of this important component of Head Start by providing a current snapshot of health-related activities and programming within HS/EHS programs, describing the context in which the health services area operates, and identifying the current needs of health managers and other staff as they work toward improving the health of HS/EHS children, families, and staff.

To accomplish this objective, the study designed and fielded a short online survey for HS/EHS program directors and a more in-depth online survey of the HS/EHS health mangers. All directors of HS/EHS programs in operation during the 2012–2013 program year were invited, including American Indian and Alaska Native programs and Migrant and Seasonal Head Start programs. In addition, semistructured interviews were conducted with a small number of health managers, teachers, family service workers, and home visitors. The survey data were also linked to administrative data from the Head Start Program Information Report, as well as county-level indicators and other geocoded data.

Key Findings

Staffing and managing the Head Start health services area. The health manager workforce brings relevant health-related education, training, and professional experience to the job. Overall, the health manager position is a demanding job with many challenges, but health managers are dedicated to and find satisfaction in their work. HS/EHS programs recognize the need for ongoing training and professional development in the health services area for all staff, although some training could be made more applied. The Health Services Advisory Committee serves an important function in linking a diverse array of stakeholders to HS/EHS programs.

Landscape of Head Start health programs and services. Overweight and obesity, as well as tooth decay, are consistently at the top of the list of health concerns identified by health managers for both children and adults. To address these and other health issues, HS/EHS programs coordinate an array of screening and follow-up services, support access to health care providers, and engage in an array of prevention and health-promotion activities. The variety of sources of information involved in tracking child health information and the frequency with which records must be updated to meet Head Start requirements are viewed as burdensome.

Prioritizing, implementing, and sustaining Head Start health services. Health managers draw on varied resources to inform their prioritization and implementation of health services and activities. Multiple approaches are used to engage families and obtain buy-in from teachers and other staff. Monitoring efforts focus on process rather than outcomes, with health managers reporting that they lack time or expertise to undertake more-rigorous evaluation.

Community partnerships and other resources supporting the Head Start health services area. Programs work with an array of health care providers and other community partners through formal and informal arrangements. Developing and maintaining these relationships, while viewed as valuable, also requires a significant investment of time and some gaps exist.

Crosscutting issues. Health managers identified a number of crosscutting issues: There are too many requirements and not enough time to complete them; there is a lack of clarity around some Head Start standards; providers do not always offer required health screens and services; and programs are being held accountable for family or provider behavior.

Findings from this study will inform future training, technical assistance, staffing, policies, and research on the health services area, which collectively will have a meaningful and measurable effect on the health of children and families being served by HS/EHS programs.

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Summary

> *There is a lot that goes into being the health manager of a program because "health" encompasses all the components of Head Start. . . . In my experience working with other individuals in the health positions of Head Start for several years, the health component really is the largest component of the Head Start program.* —2012–2013 Head Start Health Manager Survey respondent

From Head Start's origins, a central objective has been a "healthy start," stemming from the recognition that early health provides a critical foundation for school readiness and later school success. For this reason, the health services area has been and continues to be a core component of Head Start and Early Head Start (HS/EHS) programs. As stipulated in the Head Start Program Performance Standards, programs have an array of health-related responsibilities, such as making a determination of current health status; screening for developmental, sensory, and behavioral concerns; supporting access to ongoing health care; fostering communication between staff and families; addressing health and safety issues; providing nutrition services; and supporting individualized health services. Early Head Start (EHS) programs, along with Migrant and Seasonal Head Start (MSHS) programs, also address health needs for pregnant women, infants, and toddlers.

Primary responsibility for planning for and implementing these health-related services is vested in the health manager (or health services manager). Together with other HS/EHS program staff, consultants, and community partners, the health manager works with enrolled children and their families to ensure that they are up-to-date on a schedule of recommended age-appropriate preventive and primary health care (including immunizations), have access to continuous health and dental care, maintain health insurance coverage, receive routine preventive care and follow-up, receive health and developmental-related screenings and follow-up, have access to mental health services as needed, and practice a wealth of health-promoting behaviors.

Despite the long-standing commitment to health services as a central component of Head Start, it is a relatively understudied aspect of the program. It has been nearly 20 years since a focused study examined the role of the health manager and how HS/EHS programs approach the health services area. When the last comprehensive study was conducted, EHS was not yet in place and the study was not designed to fully capture American Indian and Alaska Native (AIAN) programs or MSHS programs (also known as Region XI and Region XII programs, respectively).

The overall purpose of the Head Start Health Manager Descriptive Study is to fill this knowledge gap by providing a current snapshot of health-related activities and programming within HS/EHS programs. The aim is to better understand the context in which the health services area operates and to identify the current needs of health managers and health staff as they work toward improving the health of HS/EHS children, families, and staff. The study is intended to provide descriptive information about services currently provided and the challenges

that HS/EHS programs face. Notably, the study is not designed to ascertain whether HS/EHS programs are meeting requirements set forth in the health-related Head Start performance standards.

In the remainder of this summary, we first detail the study objectives and provide a high-level overview of the study approach, which involved designing and fielding a new survey and conducting more-detailed follow-up interviews. We then highlight a series of findings that emerge from the quantitative and qualitative analyses based on the data collected. A final section outlines a number of implications for the health manager workforce and for the Head Start health services area.

Study Objectives and Approach

Although HS/EHS programs provide annual updates through the Head Start Program Information Reports (PIRs) on some aspects of the health of participating children and families and other aspects, such as their health insurance coverage, there is little representative information collected about the breadth and depth of health services within HS/EHS programs and how the staffing structure and community resources support the health services area. There is also a need to gain a deeper understanding of the processes that health mangers use to prioritize health topics for more-focused health initiatives; how the managers develop, select, and adapt curricula; and approaches they use to sustain such initiatives over time. Understanding how health mangers use national, state, and local data to monitor and prioritize health issues, as well as learning more about decisionmaking processes with respect to the design and implementation of health services, is critically important to ensuring that technical supports and services provided by the Office of Head Start (OHS) are meeting the needs of the programs in a way that is accessible, useful, and actionable to health managers. Central to the successful uptake of promising health practices and policies is the ability to "translate" them, making them implementable and actionable in a wide range of settings—this is particularly important given that some health managers are responsible for health services across a large and diverse group of centers.

With this motivation, the Head Start Health Manager Descriptive Study has four specific goals:

1. Describe the characteristics of health managers and related staff in HS/EHS programs.
2. Identify the current landscape of the Head Start health services area and what is being offered to children and families.
3. Determine how Head Start health initiatives are prioritized, implemented, and sustained.
4. Identify the programmatic features and policy levers that exist to support Head Start health services, including staffing, environment, and community collaboration.

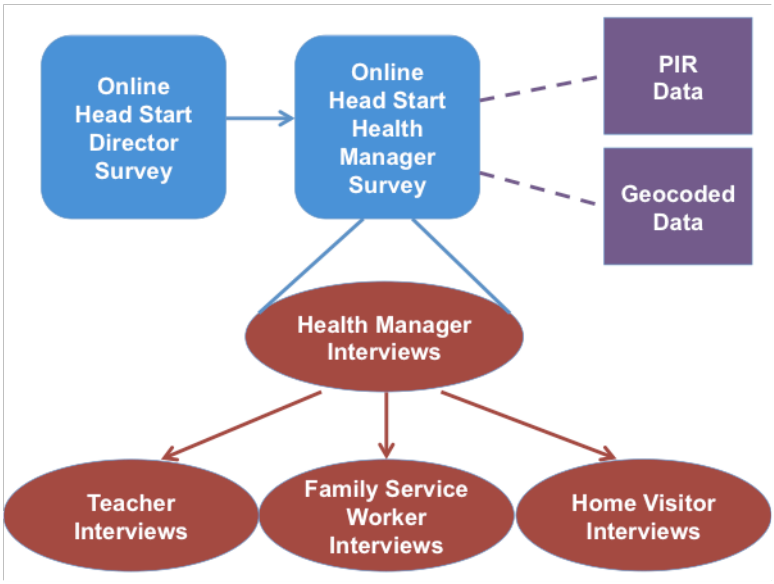
To achieve these objectives, the study was guided by an organizational framework that was shaped by an understanding of the key stakeholders involved in planning for, implementing, and participating in the Head Start health services area, as well as how those stakeholders work together to inform and implement components of the health services area, including health

management of children (e.g., administering medication), screening (e.g., vision and hearing), referrals for health services (e.g., referrals to specialists or behavioral health services), prevention and health-promotion activities (e.g., hygiene, safety), staff wellness (e.g., weight management, smoking), and facilitation of community linkages (e.g., with providers). Given the objectives and the breadth of the topics required to achieve them, the study was not able to provide in-depth treatment of other important aspects of health in the context of Head Start, such as the health issues and needs facing the children and families served by HS/EHS programs.

The organizational framework was used in the development of the instruments for primary-data collection. As illustrated in Figure S.1, the study involved the collection of primary data using two modes: (1) an online survey of HS/EHS directors and another online survey of HS/EHS health managers (blue boxes) and (2) a set of semistructtured interviews with a subset of HS/EHS health managers, teachers, family service workers, and home visitors (red ovals). HS/EHS programs in all ten Head Start geographic-based regions (Regions I to X), as well as Region XI AIAN programs and Region XII MSHS programs, were included in the surveys and interviews. These new data were combined with two existing data sources (purple squares): Head Start program administrative data from the PIR and publicly available geocoded data sets relevant to Head Start and the health services area. The ability to link to the PIR allowed the online survey to complement, not duplicate, information already collected from HS/EHS programs (grantee and delegate agencies). The geocoded data provide additional contextual information from which to characterize the health needs and resources in the communities where HS/EHS programs operate. As required under the 1980 Paperwork Reduction Act, the study protocol was reviewed and approved by the Office of Management and Budget (OMB) (OMB approval number 0970-0415). The RAND study team, together with the Administration for Children and Families and the project Technical Working Group (TWG), took great care to ensure that the ways in which the study was designed, approved, and launched accounted for and was respectful of tribal culture and history around research with tribal populations. Similar attention was given to the relevance of the data-collection instruments and methods for Region XII MSHS programs.

The primary-data collection took place between December 2012 and November 2013. We now briefly describe the components of primary-data collection in turn.

Figure S.1. Relationship of Study Data Components



Online Surveys of Directors and Health Managers

Head Start Director Survey

Based on contact information available in the Head Start PIR, directors for HS/EHS grantees and delegate agencies as of November 2012—including AIAN and MSHS programs—were invited to complete the short (15-minute) online Director Survey to obtain basic information about the HS/EHS program and the activities in the health services area. The questions covered the special populations served by the program; the overall budget and budget for the health services area; the director's role with the Health Services Advisory Committee (HSAC); and the director's education, training, and demographic characteristics. The director was also asked to provide the names and contact information (i.e., email address) for the health managers in her or his program. The survey was administered using RAND's Multimode Interviewing Capability (MMIC^{TM}) survey system, a computer-assisted data-collection program. Respondents using the MMIC interface were given a unique login and password, so the status of their surveys could be tracked. Respondents were able to begin the survey online, save responses, and return later to the instrument if they were not able to complete the survey in one session. A total of 1,627 directors (out of 1,965 eligible to participate) responded to the online survey and provided a referral to one or more health managers, for an 83 percent response rate. Because some directors were responsible for more than one program (e.g., an HS program and an EHS program), the responding directors represent 84 percent (2,330) of the 2,778 HS/EHS programs active in the 2012–2013 program year.

Head Start Health Manager Survey

The 1,627 directors made referrals to 2,013 health managers. As directors completed their surveys, the contact information they provided for one or more health managers was used to invite them to complete the online Health Manager Survey. The Health Manager Survey questionnaire took about 45 minutes to complete and covered more-detailed information about the health manager and that role, the role of other HS/EHS staff, management of health conditions among children and families, screening and referral processes, health promotion and disease prevention, staff wellness, and community linkages. The survey instrument included core questions administered to all respondents and a set of supplemental questions, divided into four modules. Respondents were stratified and then randomly assigned to respond to one of the four supplements, so about one-quarter of the respondents answered each set of supplemental questions. No incentives were offered for completion of the survey. A partial survey was received for 124 health managers, and 1,341 health managers completed the full online survey. Thus, the response rate for the Health Manager Survey, including the partial respondents, was 73 percent. Some health managers serve the same program; others serve more than one program (e.g., an HS program and an EHS program administered by the same agency). On balance, the 1,465 responding health managers represented 1,902 programs, or 68 percent of the 2,778 eligible HS/EHS programs.

Although the goal was to obtain as close as possible to a 100 percent response for the online surveys, we anticipated that there would be some degree of nonresponse and that analytic weights would be needed to account for any selectivity in which directors and health managers responded to the survey. With key characteristics of all HS/EHS programs known a priori through information available in the PIR, we constructed nonresponse weights based on a subset of those program characteristics (e.g., program type, size, and region). These weights are used when calculating means or percentage distributions across survey responses. By using weights, we can generalize study findings to all health managers or all HS/EHS programs.

Semistructured Interviews with Health Managers and Other Staff

Health Manager Interviews

In order to obtain more in-depth information not possible with a structured survey questionnaire, a purposive sample of health managers who completed the online survey was invited to participate in a semistructured telephone interview to probe more deeply into the topics covered by the online survey. We had a goal of 40 interviews, so the respondents were selected to ensure that they captured variation along key HS/EHS program features, namely HS/EHS program model (e.g., HS versus EHS), program options (e.g., home- or center-based models), and Head Start region. The final sample of 38 health manager interviews represents a 59 percent response rate based on the number invited to participate.

Teacher, Family Service Worker, and Home Visitor Interviews

In recognition of the important role played by other HS/EHS staff in the delivery of the health services area, the health managers selected for an interview were asked to nominate teachers, family service workers, and home visitors in their programs who might be willing to be interviewed. Those individuals were then invited to complete a semistructured telephone interview to learn more about their roles in the provision of the health services area. Our goal was to achieve 60 interviews in total, and we completed 52 interviews, for a 46 percent response rate.

We analyzed all interview data according to standard practices, including grounded theory, using ATLAS.ti.

Analytic Approach

Given the nature of the study objectives, this study was designed to be descriptive. For all survey questions, we examined results separately for HS programs and EHS programs. For questions on the Director Survey and in the core Health Manager Survey, the number of respondents supported further subgroup analyses. In particular, we considered differences in the survey responses based on the health manager's health-related education background (none, an associate degree, or a bachelor's degree or higher), program size based on funded enrollment (up to 150 slots, 151 to 349 slots, and 350 slots or more), and program rural-urban status based on geocoded information (programs in mostly rural areas, mixed rural-urban areas, and urban areas).

The administration of the online survey for HS/EHS programs in all regions ensures that that variability is reflected in the survey results. At the same time, the study did not seek to capture individual child or family data or to measure program compliance with respect to Head Start performance standards. In the main report, therefore, we present the results of online surveys in aggregate or for subgroups in such a way that results for individual HS/EHS grantees or staff cannot be identified. Quotes from the semistructured interviews are incorporated into the narrative, but respondents are only identified by role.

Findings from the Head Start Health Manager Descriptive Study

In this section, we distill the detailed portrait of the health services area that emerges from the survey and interviews into a number of key findings. These high-level findings are meant to convey the broader-based conclusions that flow from our analyses and should not obscure the fact that the way the health services area is structured and delivered is far from uniform across the country's nearly 3,000 HS/EHS programs.

Our discussion of the findings centers on four themes: staffing and managing the Head Start health services area; the landscape of Head Start health programs and services; planning, implementing, and sustaining Head Start health services; and community partnerships and other resources supporting the Head Start health services area. We also mention several crosscutting issues. Finally we summarize how results differed for HS programs versus EHS programs and

for AIAN (Region XI) and MSHS (Region XII) programs. The key findings are summarized in brief in Table S.1.

Table S.1. Summary of Key Findings

Staffing and Managing the Head Start Health Services Area
• The health manager workforce is diverse in terms of personal characteristics and brings relevant health-related education, training, and professional experience to the job • The health manager position is a demanding job with many challenges, but health managers are dedicated to and find satisfaction in their work • Many HS/EHS staff and consultants contribute directly or indirectly to the health services area • HS/EHS programs recognize the need for ongoing training and professional development in the health services area for all staff, although some training could be made more applied • The HSAC serves an important function in linking programs to a diverse array of stakeholders and providing supportive resources for HS/EHS programs
Landscape of Head Start Physical, Behavioral and Mental, and Oral Health Programs and Services
• Geocoded data demonstrate that HS/EHS programs are in diverse communities with, on average, more minorities, high child poverty, and shortages in health care resources, compared with the U.S. average • Health managers identified an array of health concerns affecting children and families, although overweight and obesity and tooth decay are consistently at the top of the list • Almost all HS/EHS programs track child health information using a formal (electronic) system, but the variety of sources involved and the frequency with which records must be updated are viewed as burdensome • Almost all programs reported conducting the required health screenings (e.g., developmental, sensory), and other screenings as well, using a variety of strategies to ensure that screenings are performed and that parents follow up where indicated • A range of health services is offered on-site, such as speech therapy, behavioral or mental health services, care or therapy for children living with disabilities, and oral disease prevention (e.g., fluoride), and most programs offer multiple services • Most programs provide a number of other health-related services (e.g., assistance enrolling in insurance coverage, parent education and workshops), which extend the comprehensive nature of what is offered • For all types of health services (screenings, physical health, behavioral and mental health, and oral health), health managers identified several common barriers to ensuring that children receive needed services • HS/EHS programs address a wide array of health promotion topics in classrooms, with parents, and in the home, but programs do not always use evidence-based curricula • Staff-wellness activities are less common than the health-promotion activities offered for families

Table S.1. Summary of Key Findings, *Continued*

Prioritizing, Implementing, and Sustaining Head Start Health Services
• Health managers draw on a wide range of resources to inform their choices of health services and activities in the areas where they have the most discretion (e.g., staff training, health promotion) • Health managers use varied approaches for prioritizing and implementing health activities, with processes tailored to the specific circumstances of activities implemented with staff, in the classroom, with parents, or in the home • Programs use multiple strategies to engage families in the full range of health services and supports; obtaining buy-in from teachers and other staff is also important • Funding for health services comes primarily from program funds, public or private health insurance coverage, and in-kind contributions from providers • Monitoring efforts focus on process rather than outcomes, with health managers lacking time or expertise to undertake more-rigorous evaluation
Community Partnerships and Other Resources Supporting the Head Start Health Services Area
• To coordinate physical health services, most programs rely on formal mechanisms with providers (e.g., memoranda of understanding [MOUs]), and most programs view their partnerships as adequate or very adequate • Formal mechanisms also predominate in relationships with behavioral and mental health providers, but these mechanisms are somewhat less likely to be viewed as adequate or very adequate • Compared with physical health services, partnerships with oral health providers are somewhat less likely to be formalized or viewed as adequate or very adequate • Programs work with a wide range of other community partners, and, while these relationships are viewed as valuable, they also require a significant investment of time to develop and maintain, and some gaps exist
Crosscutting Issues Identified by Health Managers
• There are too many requirements and not enough time • There is a lack of clarity around some Head Start performance standards • Providers do not always offer health screens and services required for Head Start • Programs are being held accountable for parent or provider behavior • Some health managers perceive that their Head Start program leadership or OHS places a lower priority on the health services area

Staffing and Managing the Head Start Health Services Area

A central objective for the study was to understand the characteristics of the health manager workforce and the role that health managers and other HS/EHS staff have in the provision of the health services area. The role of the HSAC was also of interest. Results based on the survey responses and interviews contribute to several findings.

The health manager workforce is diverse in terms of personal characteristics and brings relevant health-related education, training, and professional experience to the job. Health managers are predominately female and come from varied racial, ethnic, and linguistic backgrounds. Two out of three health managers have at least a bachelor's degree, and coursework or degrees in health-related areas is almost universal. Just over one-half have a health-related license, certificate, or credential, with a nursing-related credential being most common. Overall, 25 percent of health managers reported having an active registered nurse (RN) license; 11 percent have an active licensed practical nurse (LPN) license. Accounting for highest degree; degree fields; and health-related licenses, certificates, or credentials, about 59 percent of health managers have a bachelor's degree or higher in a health-related field or in combination with a health-related license, certificate, or credential. Just 14 percent have no health-related education background (i.e., a postsecondary degree or license, certificate, or credential). Many have prior experience with HS/EHS in other staff roles or as parents, and most have experience working with children from birth to age five.

The health manager position is a demanding job with many challenges, but health managers are dedicated to and find satisfaction in their work. Most health managers are responsible for multiple sites, and it is typical that the health manager has one or more additional roles within the program, although the health manager role is usually primary; secondary roles often relate to the health services area (e.g., nutrition manager/coordinator). The multiplicity of roles for health managers is frustrating for some who would like to devote more time to their responsibilities in the health services area. The job typically requires a full-day, year-round schedule, and health managers noted in interviews that compensation does not often reflect the professional qualifications of the individuals who serve in the role. Challenges are associated with working with families to achieve health objectives; meeting Head Start program requirements; and having sufficient resources of time, staff, and budgets to achieve the goals for health services. Nevertheless, three out of four health managers reported being satisfied or very satisfied with their job.

Many HS/EHS program staff and consultants contribute directly or indirectly to the health services area. While health managers have oversight for the health services area, many other staff have direct responsibility for specific components, such as teachers performing daily health checks, a nutrition manager/coordinator making menu plans, and a family service worker helping families access public health insurance. Many programs rely on paid consultants for key functions, or to augment health services, such as nutrition and mental health services.

Coordination among the staff is key, although programs vary in the frequency of routine communications among the staff.

HS/EHS programs recognize the need for ongoing training and professional development in the health services area for all staff, although some training could be made more applied. Given the range of expertise needed, health managers reported accessing training on a wide array of topics, with most training occurring locally. In interviews, health managers noted the need for orientation supports for those new to the role. Health managers reported interacting with their peers to share experiences and learn about new initiatives, but a nontrivial share (16 percent) reported no such connections in the prior year. Staff who were interviewed expressed the need for more training that had concrete, actionable steps to implement in the classroom or home setting.

The HSAC serves an important function in linking programs to a diverse array of stakeholders and providing supportive resources for HS/EHS programs. Health managers reported that there was a wide range of experts and community stakeholders on HSACs, including other program staff, health care providers, public agency representatives, health experts, and parents or guardians. To accommodate all these representatives, the typical HS/EHS program has an HSAC with 15 members, although not all members are considered active. Most health managers stated that their HSAC members mirror the ethnic, cultural, and linguistic backgrounds of the children and families they serve. The health managers we surveyed generally agreed that their HSACs support the development and maintenance of community partnerships, help programs stay abreast of issues and best practices, and support internal functions relating to health services and program policies and procedures.

Landscape of Head Start Physical, Behavioral and Mental, and Oral Health Programs and Services

A second major goal of the study was to develop a deeper understanding of the nature of the services and activities conducted as part of the Head Start health services area, including the health management of the individual child, health-screening services and follow-up, physical health services, behavioral and mental health services, oral health services, and prevention and health promotion. The study also sought to better understand home-based services, services for pregnant women, and staff wellness and to understand the nature of the health issues facing HS/EHS children and families that the programming was designed to address. The survey results and in-depth interviews support the following findings.

Geocoded data demonstrate that HS/EHS programs are in diverse communities with, on average, more minorities, high child poverty, and shortages in health care resource compared with the U.S. average. The geocoded data assembled for this project are particularly relevant for understanding the context within which HS/EHS programs operate. County-level indicators show that HS/EHS programs are in communities that have a larger share of minorities and an average poverty rate for children under age five (28 percent, compared with 20 percent

for counties without an HS/EHS program). Most notably, almost one-half of all HS/EHS programs are in counties with one or more medically underserved areas, and a similar share are in counties with shortages of health professionals (e.g., primary care, mental health, and dental health). AIAN and MSHS programs are even more likely to be in counties that are medically underserved or have health-professional shortages.

Health managers identified an array of health concerns affecting children and families, although overweight and obesity and tooth decay are consistently at the top of the list. In particular, these two topics were selected by health managers in 80 percent and 76 percent of programs, respectively, as top health concerns affecting the children the programs serve. Obesity was also most frequently selected (77 percent) on a list of possible adult health issues. The high concern for child obesity is validated by PIR data showing that the average share of overweight preschoolers across HS programs is nearly 30 percent.

Almost all HS/EHS programs track child health information using a formal (electronic) system, but the variety of sources involved and the frequency with which records must be updated is viewed as burdensome. Electronic record systems are used by about 90 percent of programs for tracking child health information, yet health managers reported that such record keeping is time-consuming and is largely an administrative task. Many HS/EHS programs, however, do not have administrative staff to support health managers. Consequently, health managers felt that the aspects of the job focused on supporting families in their access to care and developing and implementing health promotion and prevention activities have to compete with the time required for record keeping.

Almost all programs reported conducting the required developmental (cognitive, social, and emotional) and sensory (hearing and vision) screenings, and other screenings as well, using a variety of strategies to ensure that screenings are preformed and that parents follow up where indicated. Oral health screening, although not explicitly required in the Head Start performance standards, is performed in 80 percent of programs. During interviews, health managers mentioned that their staff was not always trained to perform the full range of health screenings, particularly those required for behavioral or mental health and oral health, and providers may be reluctant to come on-site to perform screenings. Health managers reported employing a variety of methods to ensure that follow-up evaluations are conducted when indicated by a screening, including follow-up with parents and providers. Programs also provide an array of supports to families to help ensure follow-up evaluations, including delivering information about what the evaluation will entail, assisting with accessing insurance, helping to schedule the follow-up evaluation, and providing evaluations on-site.

A range of health services is offered on-site, and most programs offer multiple services. Health managers work with a number of professionals in the community to make a range of services available on-site. The most common services offered on-site include speech therapy, behavioral or mental health services, care or therapy for children living with disabilities, and oral disease prevention (e.g., fluoride). About one-third of programs also provide oral health

treatment (i.e., dental exam) on-site through a mobile or portable dental program. In addition to the services provided on-site, health managers and staff play a role in linking children to needed health services off-site. A key challenge is ensuring that parents follow through and complete recommended treatment, although HS/EHS staff provide a range of supports to the family, such as accompanying parents to appointments or assisting with translation services. A shortage of providers, such as pediatric dentists, was cited as another barrier in some circumstances.

A majority of programs provide a number of other health-related services, which extends the comprehensive nature of what is offered. These other services include information about health insurance and assistance enrolling, workshops on education and parenting, health-related events for the entire family, health and social services offered in collaboration with service agencies (e.g., hospitals), and health literacy services. Services for pregnant women—such as providing relevant information (e.g., about nutrition, breast-feeding, child development), referrals to health care providers, and help with finding baby care items—are offered almost universally in EHS programs. Services provided in the home setting (e.g., teaching parents and children about healthy behaviors, nutritional services, and health screenings) are also offered by a majority of EHS programs.

For all types of health services (screenings, physical health, behavioral and mental health, and oral health), health managers identified several common barriers to ensuring that children receive needed services. Regardless of the health services area, the most prevalent response was parents or guardians not understanding the importance of screening and treatment services or not open to talking about the services. Other prominent barriers pertain to communication (e.g., phone numbers or addresses not being current) or various resource constraints (e.g., lack of transportation, lack of parental time, issues with insurance coverage). Gaps in the availability of medical providers (generalists and specialists) appear to play a smaller role.

HS/EHS programs address a wide array of health promotion topics in classrooms, with parents, and in the home, but programs do not always use evidence-based curricula. Topics addressed by close to 90 percent of programs include nutrition or healthy eating practices, oral hygiene, and physical activity or fitness. Health managers reported using an array of different curricula and other resources in support of these activities, but most resources are not widely used, and the effectiveness of many of the resources employed is not known. About one-half of programs reported lack of parent or family interest, which was one of possible barriers to implementing health-promotion activities with parents and families. Lack of family time was also commonly cited.

Staff wellness activities are less common than the health-promotion activities offered for families. Wellness activities available to staff in at least one-half of all HS/EHS programs included injury prevention and safety, stress management, physical activity and fitness, and weight management or nutrition information.

Prioritizing, Implementing, and Sustaining Head Start Health Services

To support health managers in their role, it is important to understand the strategies and resources health managers use to prioritize, implement, and sustain the health services area. Although the Health Manager Survey included a number of questions on these topics in regards to prevention and health-promotion activities, these issues were better explored in the less structured interview format. Thus, our findings that follow rest largely on more-qualitative analyses of the interviews with health managers and other program staff.

Health managers draw on a wide range of resources to inform their choices of health services and activities in the areas where they have the most discretion. These areas include topics for staff training and the set of health promotion and prevention activities. Common resources that health managers turn to in planning these initiatives include the OHS Early Childhood Learning and Knowledge Center, various national organizations, community providers, and other health managers. In the case of resources and materials to use with families, health managers were concerned that the reading level was often too high for the families they served and that resources were not always available in languages other than English and Spanish.

Health managers use varied approaches for prioritizing and implementing health activities in their programs, with processes tailored to the specific circumstances of the activities implemented with staff, in the classroom, with parents, or in the home. Health managers pointed to annual community assessments, self-assessments, parent surveys, and HSAC feedback as inputs to determining which health activities would be prioritized within their programs. Staff training topics are selected based on staff feedback and other priorities or needs. The extent to which health-promotion activities were introduced with families during home visits varied, with the selection of health topics being driven primarily by parents as part of family goals.

Programs use multiple strategies to engage families in the full range of health services and supports. For example, programs use varied strategies to encourage families to follow through with evaluations and treatment services. Likewise, programs use multiple approaches to communicate with parents about health-promotion activities and offer incentives to encourage parent participation (e.g., serving food or snacks, offering child care, or offering door prizes). Health managers also noted the importance of teacher buy-in for successful implementation, as well as communication with home-visiting staff.

Funding for health services comes primarily from program funds, public or private health insurance coverage, and in-kind contributions from providers. These sources of funding are used, to varying degrees, to support screening services, treatment services, and prevention and health-promotion activities. For screening services, the two most prevalent sources of funding are public health insurance and the program's budget. Public and private insurance coverage are the most prevalent sources of funding for treatment services, while program funds and provider in-kind contributions are most likely to be used to fund health-

promotion activities. About two in three programs reported having a separate budget to support services for medical, behavioral and mental, and oral health treatment.

Monitoring efforts focus on processes rather than outcomes, with health managers lacking the time or expertise to undertake more-rigorous evaluation. Although programs monitored the health of individual children, far fewer programs reported that they monitor or evaluate the effectiveness of their health programming or health-promotion activities, citing a lack of time and expertise to do any rigorous evaluation. Programs did report tracking health-promotion activities, but most of these activities are either process-based (e.g., we track what activities we do) or fall under metrics that the program is already collecting (e.g., weight and height of children).

Community Partnerships and Other Resources Supporting the Head Start Health Services Area

Through the requirement for an HSAC, the Head Start performance standards recognize the importance of strong ties to health care providers, health experts, and other stakeholders in the local community. For this reason, another goal of the study was to understand the nature and strengths of existing community partnerships and other resources that support the Head Start health services area. Information was gathered about partnerships in the context of specific health services. In addition, the broader range of partnerships with other community organizations was explored. Here we mention the findings regarding these potentially vital resources.

To coordinate physical health services, most programs rely on formal mechanisms with providers (e.g., MOUs), and most programs view their partnerships as adequate or very adequate. Such formal relationships are most common with general health care providers in private practice or in Federally Qualified Health Centers (FQHCs), with generalists or specialists from state or local health departments, and with nutritionists. The most prevalent features of these formal arrangements include provisions for membership on the HSAC, consultation, and training of HS/EHS program staff. The vast majority (84 percent) of program health managers stated that their partnerships with physical health providers are adequate or very adequate for meeting the physical health needs of the children the programs serve.

Formal mechanisms also predominate in relationships with behavioral and mental health providers, but they are somewhat less likely to be viewed as adequate or very adequate. Formal mechanisms, such as MOUs, are most common for partnerships with state and local agencies providing services for behavioral or mental health and with private for-profit or nonprofit behavioral or mental health providers. Such partnerships are most likely to include the provision of behavioral or mental health services to children and families at HS/EHS sites, training for HS/EHS staff, consultation, and the provision of behavioral or mental health services at other sites. Compared with physical health providers, health managers were somewhat less

likely to state that their partnerships are adequate or very adequate for addressing the behavioral or mental health needs of the children in their programs (76 percent versus 84 percent).

Compared with physical health services, partnerships with oral health providers are somewhat less likely to be formalized or viewed as adequate or very adequate. Just 80 percent of programs reported formal relationships with oral health providers (compared with 97 percent for physical health providers). When formal mechanisms exist, common features include providing for oral health services for children and families at HS/EHS sites and resource payments to providers. The share of programs rating their oral health provider partnerships as adequate matches the rate for behavioral and mental health providers (76 percent).

Programs work with a wide range of other community partners, and, while viewed as valuable, these relationships require a significant investment of time to develop and maintain, and some gaps exist. Beyond the partnerships with health services providers discussed above, the two most common partners mentioned by health managers are food and nutrition agencies and local health departments or public health departments. Partnerships are also common with community health centers or local hospitals, social service agencies, and public schools. For those organizations where partnerships exist, the agencies or organizations might provide health services, health education, or referrals, among other supports, often without charge. During interviews, health managers noted that such partnerships, while valuable, require a significant amount of time to cultivate and foster. Weight-control services were most often reported as the health need that requires additional partnerships (36 percent). About one-quarter of programs reported gaps in community partners to address smoking cessation, alcohol and substance abuse, environmental health concerns, oral health care, and behavioral health care.

Crosscutting Issues Identified by Heath Managers

Although not a direct focus of the study, a number of crosscutting issues emerged, largely from the interviews with health managers and other HS/EHS staff and to a lesser extent from survey responses.

There are too many requirements and not enough time. A consistent theme throughout the survey response and interviews is the time constraints faced by health managers. Health managers felt that the amount of time required to track every child against every requirement precluded them from doing other health-related activities, such as prevention and health-promotion activities and the evaluation of those efforts, which health managers considered to be more important for health and a better use of their skills and training.

There is a lack of clarity around some Head Start performance standards. During interviews, health managers noted that the Head Start standards in the health services area are not overly prescriptive in some areas. While this is helpful in some regards, the ambiguous nature of the standards results in some health managers feeling like they do not fully understand what is expected of them or the health services area.

Providers do not always offer health screens and services required for Head Start. Many health managers reported significant amounts of time required to educate providers on the need to comply with Head Start requirements. Health managers mentioned numerous instances where providers were not conducting necessary screenings (e.g., those required for Early and Periodic Screening, Diagnostic, and Treatment). This issue increases the workload for the health manager who must convince each clinician to conduct the required tests. Furthermore, the issue creates a tension as health managers might be perceived as undermining the trust the clinician has built with the family.

Programs are being held accountable for parent or provider behavior. A related issue is that health managers felt that it was unfair to hold them accountable for the actions (or lack thereof) of parents and providers with whom they have been working. Health managers noted that perhaps there should be additional strategies to ensure that families are more accountable for attending provider visits and following up on needed health services for children.

Some health managers perceived that the health services area receives lower priority. Several health managers reported that, overall, there seems to be a lack of emphasis on the health services area on the part of OHS and program leadership relative to other areas of programming (e.g., school readiness) and that what emphasis is there is has declined over time. Health managers were concerned that this is contributing to cuts in health personnel and budgets.

Health Services Area in Head Start Compared with Early Head Start

The findings summarized above apply equally well to the health services area in EHS and in HS. As would be expected given the differences in the focus on pregnant women, infants, and toddlers in the former and preschool-aged children in the latter, there are differences in the underlying health concerns and opportunities for health promotion and therefore in the corresponding priorities for health screening, treatment, prevention, and promotion. In many cases, however, health managers are overseeing the health services area for grantees or delegate agencies that operate both one or more HS programs and one or more EHS programs As a result, there is a high degree of overlap, from an administrative perspective, in how the health services area is managed across HS/EHS programs.

Head Start Health Services in AIAN and MSHS Programs

One goal for this study was to be inclusive of all HS/EHS programs. Additional resources were devoted to seeking approval to include AIAN HS/EHS directors and health managers in the online survey frame and in the semistructured interviews. MSHS HS/EHS programs were included as well. It is important to note, however, that AIAN programs do not exclusively serve AIAN children and families, and many AIAN children and families attend HS/EHS programs in non-AIAN programs. The same is true for migrant and seasonal families who may attend non-MSHS programs.

For questions included in the core survey (not the supplements), we report results for all HS/EHS programs together and for AIAN and MSHS programs separately to highlight the patterns for these two special Head Start components. In many respects, our results show that AIAN and MSHS programs, on average, mirror many of the same features as the average HS/EHS program nationwide. Thus, the central findings of the study apply equally well to AIAN and MSHS programs. Despite these broad similarities, a few differences emerged for programs in these two regions. It is important to keep in mind that any differences we observe for AIAN and MSHS programs may reflect underlying variation in the population of children and families they serve, in the internal and external resources available to the HS/EHS program, and in the background and competencies of the health manager and other health services area staff. As a descriptive study, we are interested in documenting the patterns but are not able to explain the reasons for any differences we observe.

With that caveat in mind, for AIAN programs, we find the following differences from the overall results:

- Based on county-level indicator and geocoded data, AIAN programs are more likely to be in counties with a shortage of mental health professionals. The centers operated by AIAN programs are also less likely to have nearby health-related resources, such as mental health providers who accept Medicaid, an FQHC, a hospital, or a health-related professional school.
- According to Health Manager Survey responses, a majority of the health managers (60 percent) in AIAN programs are American Indian or Alaska Natives.
- AIAN health managers have a lower rate of health-related licenses, certificates, and credentials, especially an RN. Consequently, one in four AIAN health managers has no health-related education background. However, they reported more experience in prior HS/EHS positions compared with the national average.
- Health managers in AIAN programs typically have oversight over a smaller number of sites than the average health manager nationwide. At the same time, AIAN health managers are more likely to serve in other roles. They also reported less frequent contact with other health managers.
- Compared with the national pattern, AIAN health managers were more likely to mention ear infections, diabetes, and child abuse and neglect as major health concerns facing children in their programs. They placed somewhat less weight on asthma or other lung diseases and overweight or obesity as child health concerns. In terms of adult health concerns, AIAN health managers were more likely to mention diabetes, alcohol abuse, and drug dependence.
- Health managers in AIAN programs are often more likely to be underresourced. As an example, AIAN program health managers reported a greater reliance on a paper or manual filing system for tracking child health information rather than an electronic one. AIAN programs are also considerably less likely than programs, on average, to have a set budget to pay for treatment services. To support such services, AIAN programs rely less on their own budgets and more on other sources, such as the Indian Health Service (IHS).
- For the most part, the provision of on-site health services in AIAN programs is very similar to the average HS/EHS program. Two exceptions are that AIAN programs are

more likely to offer on-site oral disease prevention but less likely to offer on-site physical therapy.

- Health managers in AIAN programs, compared with all HS/EHS programs, were somewhat less likely to view their current partnerships with physical health providers as adequate for meeting the needs of children living with disabilities. They were also less likely to rate their relationships with behavioral and mental health providers as adequate, but there was no difference with the equivalent rating of oral health providers. In addition, AIAN programs were somewhat more likely to report unmet partnerships needs related to injury prevention or safety concerns, as well as services for children living with disabilities.

For MSHS programs, there are also a few salient differences:

- The county-level indicators and geocoded measures of health resources show that MSHS programs are more likely to be in counties with shortages in health professionals and to have centers located at greater distances from health-related providers and facilities.
- About one in four health managers in MSHS programs is Latina or Latino, higher than the share for the overall HS/EHS health manager workforce (6 percent). Health managers are also more likely to have a health-related education background, compared with the overall average, with 72 percent having a health-related bachelor's degree or credentials.
- Health managers in MSHS programs typically have oversight over a larger number of sites, compared with the average health manager nationwide, but they are more likely to exclusively serve in the health manager role. They also have fewer interactions with peer health managers.
- In MSHS programs, it is more common for the health manager to manage multiple HSACs and to share their HSAC with another program, typically another MSHS program.
- The prevalence of major health concerns facing children in MSHS programs also differed from the national pattern, with more mentions by health managers of overweight and obesity and tooth decay or cavities but less emphasis on child abuse and neglect, attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD), and autism.
- Compared with HS/EHS programs overall, MSHS programs have a higher share offering several types of on-site services: physical exams, immunizations, and oral disease prevention. Several other services are less likely to be offered on-site—namely, behavioral or mental health care, physical therapy, and speech therapy.
- To pay for treatment services, MSHS programs were more likely to report using several sources of funding that are less commonly used by programs overall—specifically, grant funding and county indigent funds.
- Health managers in MSHS programs were less likely than health managers nationally to rate their current partnerships as adequate for meeting the physical health needs of children living with disabilities. These health managers' ratings of the adequacy of relationships with behavioral and mental health and oral health providers were comparable to the rates for all HS/EHS programs. At the same time, health managers in MSHS programs were more likely to report a need for community partnerships around food and nutrition services, higher-education institutions, and religion-based organizations.

- For the most part, health managers in Region XII MSHS programs identified a similar set of barriers to working with families in the health services area as other programs nationally. Lack of family interest was not rated as that big of a challenge, but having limited time to implement activities and competing priorities were more often mentioned.

Variation in Survey Responses by Heath Manager and Program Characteristics

In addition to examining survey responses separately for HS programs and EHS programs, as well as for AIAN and MSHS programs, we explored patterns using three other stratifying variables: health managers' health-related education backgrounds, program size, and programs' rural-urban status. Again, our analyses were limited to those questions asked in the core survey, so we could not examine differences across all topic areas covered by the survey. Further, these analyses were intended to be exploratory rather than explanatory. We briefly review the most salient differences we identified for these three factors.

Health Managers' Health-Related Education Backgrounds

As noted earlier, health managers bring varied education, training, and experience to their role. Given that this is an area of program discretion, we have an interest in understanding whether there are differences in how the health services area is organized and functions based on the health manager's background. Taking into account highest degrees; degree fields; and health-related licenses, certificates, and credentials, we classified programs based on the health manager's health-related education background: (1) no health-related postsecondary degree and no health-related credentials (e.g., RN or LPN), (2) with an associate degree in a health-related field or a relevant credential, and (3) with a bachelor's degree or higher in a health-related field or a bachelor's degree or higher with a relevant health-related credential. Note that for any differences we did identify, we were not able to explain the reason for the differences. For example, differences might reflect the hiring and staffing patterns used by programs or the differential choices that health managers make in administering the health services area based on their health-related backgrounds. The variation may be explained by other factors associated with the health manager's education-related background that we do not measure, such as the differences in the needs of the families served by the program.

The health-related education backgrounds of the health managers have some relationship to their job role and how they plan for health activities. For example, those with a bachelor's degree or higher in a health field, or one or more health-related credentials, are more likely to serve exclusively in the health manager role and to have more-frequent contact with other health managers. For program planning, when the health managers have health-related bachelor's degrees, they are more likely to rely on prior use or familiarity with a curriculum, compared with health managers with no health-related degree. Health managers with a health education background are also more likely to rely on professional association websites and listservs as information resources.

In terms of the program services offered, the health manager's background is not strongly associated with the general types of services offered (e.g., medical services, services in the home, services for pregnant women). For some specific services, the services are offered at a higher rate in programs where the health manager has a health-related degree, but the differences are quite modest (e.g., differentials of at most 10 percentage points). Where difference exist, this may indicate that programs that offer various health-related services are more likely to hire a health manager with health-related education or that health managers with a health background are better able to offer these services. There are no discernible differences based on health managers' backgrounds in how adequate health managers rated their partnerships with physical, behavioral and mental, and oral health providers.

Program Size (Enrollment)

Program size, based on funded enrollment as recorded in the PIR, potentially affects the resources and capacity available to the health manager. At the same time, the management challenges may rise as the scale of the program increases. As a readily identifiable indicator, program size could be used to target programs that appear to need more supports. We examined survey responses when HS/EHS programs were stratified into three groups based on funded enrollment: small (up to 150 slots), medium (151 to 349 slots), and large (350 slots or more). Any differences in survey results we identified based on program size may reflect the role that size plays, per se, or the role of other factors that are correlated with program size.

Compared with the measure of the health manager's background, we found fewer important differences in survey responses based on program size. Some differences pertain to the structure of the health manager position and other administrative functions. In particular, health managers in smaller programs, compared with larger ones, are more likely to serve in other roles in addition to the health manager and to have less frequent contact with other health managers. We also identified differences in the size and composition of the HSAC based on program size, with larger HSACs associated with larger programs. For this reason, larger programs also have higher representation among some types of stakeholders (e.g., nutritionists, mental health specialists, oral health care providers, disability specialists), while other stakeholders are represented equally regardless of program size (e.g., HS/EHS staff, Part B and Part C partners, medical providers). In some areas, larger programs, compared with smaller ones, tend to have more formal supports for the health services area, such as an electronic tracking system. In selecting topics for health-promotion activities, health managers in larger programs appear to rely on a larger set of resources.

For the most part, the rates at which health services were offered on-site did not vary in a meaningful way with program size. There are two exceptions out of the 11 services covered in the survey. The first is a higher rate of offering physical exams and oral health treatment in large programs compared with medium or small programs, but the differences were no larger than 10 percentage points. In addition, as program size increases, EHS programs were somewhat more

likely to report that they offer services to pregnant women (92 percent for small EHS programs versus 100 percent for large EHS programs), but the specific services offered among those with services generally did not vary with EHS program size. The rates at which different approaches were taken to ensure parent follow-up were quite similar across the program-size categories. Finally, there were no important differences in how adequate health managers rated their partnerships with health providers based on program size.

Program Rural-Urban Status

The context within which HS/EHS programs operate, such as the availability of health care providers and other community partners, potentially affects how health managers and other staff deliver Head Start health services and activities. Although we gathered a number of geocoded measures to examine these issues, most were at the county level, which does not capture more-localized features of the context within which HS/EHS programs operate. Using information on the location of each center operated by the HS/EHS programs that responded to the survey and U.S. Census Bureau rural-urban classification at the tract level, we classified programs into three groups based on urbanicity: mostly rural (0 to 20 percent of centers in a Census-designated urban area or urban cluster), mixed (21 to 80 percent of centers in an urban area or urban cluster), or mostly urban (81 to 100 percent of centers in an urban area or urban cluster). Again, differences in survey results associated with urbanicity may result from differences in resource availability or the role of other factors that are correlated with rural-urban status.

In many respects, rural areas mimic the findings for small programs and urban areas mimic the findings for large programs. Health managers in programs in mostly rural areas, compared with those in mostly urban ones, are more likely to have other roles and to have less frequent contact with other health managers. As urbanicity increases, programs are more likely to have multiple HSACs and to share their HSACs. The size of the HSAC is also larger with greater urbanicity and with somewhat more varied representation. One exception is that IHS representatives are more likely to be on the HSACs for programs in mostly rural areas, compared with mostly urban ones. Programs in mostly urban areas, as with larger programs, tended to have more formalized structures and supports, such as an electronic tracking system, and rely on a wider set of resources—for example, when planning for health-promotion activities.

There is some variation in the propensity to offer specific health services by urbanicity, with the rate being higher in some instances for programs in mostly urban areas (e.g., oral health treatment and nutritional care) and the reverse pattern—a higher rate for programs in mostly rural areas—for other services (e.g., oral health prevention, care for individuals with disabilities, speech therapy). For the most part, the use of strategies to ensure parent follow-up is the same regardless of rural-urban status. The incidence of offering home-based services is lower in programs in mostly rural areas than programs in mixed or mostly urban areas. The likelihood of EHS programs offering services to pregnant women does not vary with urbanicity; among EHS programs offering services to pregnant women, there are some referral services that are less

likely to be offered by EHS programs in mostly rural areas. There are no discernible differences in how adequate health managers rated their partnerships with physical, behavioral and mental, and oral health providers based on program urbanicity.

Implications of Study Findings

These findings and the more nuanced discussion in the body of the report suggest a number of implications for the Head Start health services area. We focus in particular on those pertaining to the health services area's workforce, professional development, the health management of children, health promotion, and community linkages. We also discuss two higher-order implications related to health services area requirements and informational needs.

Implications for the Health Services Area Workforce

Health managers bring varied backgrounds to their role in terms of education, training, and experience. Although the Head Start performance standard requires staff or consultants with relevant knowledge to support the health services area, this expertise may be met by the health manager or other staff. This flexibility in how the health services area is staffed may be helpful for HS/EHS programs, but it also means that children and families may have different experience with respect to the health services area based on the skills and competencies of the health manager. OHS may wish to consider the merits of a core set of trainings specific to the health services area to ensure a consistent level of knowledge and competencies in health managers across all HS/EHS programs.

Another challenge is that many health managers reported multiple responsibilities within the program, often serving in other roles, such as nutrition manager/coordinator or behavioral and mental health manager/coordinator, in addition to their duties in the health services area. HS/EHS programs could benefit from identifying creative staffing models that provide administrative support for the health services function.

Implications for Professional Development, Training, and Technical Assistance

Although opportunities for training and technical assistance are available at conferences and regional meetings, many health managers noted that their programs do not have the budget to support their travel to or participation in these meetings. Another criticism was that trainings were often too general and lacked actionable steps or concrete examples to improve practice. Greater use of online trainings that are accessible on demand and structured to provide actionable information would allow for lower-cost uniform training.

Although some health managers reported regular contact with other health managers to share ideas and ask questions, others were not making those connections. Thus, there may be opportunities for OHS to support or encourage mentoring or networks between health managers of similar programs. Fostering such connections may be particularly beneficial for the sharing of

innovative ideas and lessons learned across programs, which may help fill the desire for more information on actionable steps.

Implications for the Health Management of Individual Children

Teachers often play an important role in managing the day-to-day health of the children in their care, and they are often the individuals engaged in day-to-day communication with families. While most teachers reported being happy to play this role, not all felt well equipped to speak with families about health issues that they knew little about, and few felt adequately trained to address major barriers (noted in this survey) related to family engagement. OHS may wish to consider training for teachers and other nonhealth staff, including family service workers and home visitors, on how to discuss sensitive health issues with families and how to ensure that families have the required knowledge and understanding of the Head Start health requirements.

Implications for Health Promotion

The selection and implementation of health-promotion activities within HS/EHS programs are quite varied. Although health managers rely on numerous sources of information, finding evidence-based curricula can be quite difficult. There may be a prime opportunity for OHS to identify or develop such curricula and to organize evidence-based resources in a centralized location, easily accessible by health managers and HS/EHS staff. In addition to being evidenced-based, attention should also be paid to the training and resources required for implementation of any given curriculum, with the aim of identifying or developing curricula that can be implemented at low cost.

Implications for Community Linkages

Health managers were resourceful in leveraging community assets to support their programs. The majority of program representatives reported that they felt good about their community linkages and the ability of their partners to help them meet the needs of the children and families they serve. While most felt good about their community partnerships, about one-quarter of health managers reported that there is room for improvement with behavioral and mental health partnerships, and oral health partnerships specifically. One challenge, however, is that in some areas the absence of a strong partnership is not the result of low interest but rather the lack of available providers. As discussed more fully in the body of the report, interviewees described several innovative models that might be more widely adopted.

Implications for Health Services Area Requirements

Health managers were almost universal in voicing a clear and consistent tension among the time, resources, and staff they have working with them and the number of requirements they are obligated to meet. In other cases, health managers felt that the requirements are ambiguous,

which leaves health managers uncertain about their approach. The planned revision of the performance standards is timely, as it provides an opportunity to ensure that the performance standards are clear and sufficiently well specified for health managers responsible for implementing them. For example, it may be possible to group the current requirements into must-haves—those requirements that are essential, core services that provide a direct health benefit to children—and nice-to-haves—which are requirements that perhaps are not essential or that require more resources relative to the expected health benefit. Although program leadership at the local level is responsible for staffing and resource allocation, the reality is that they have limited resources. Given that many health managers reported that they do not have enough resources to effectively or efficiently meet all requirements, reviewing the standards to create a comprehensive set of must-have standards that are explicitly stated could help align program resources with critical Head Start requirements.

Implications for Head Start Messaging Regarding the Health Services Area

The health services area has been a central focus of Head Start from the program's inception, and the health-related performance standards exemplify the ongoing emphasis on physical, mental and behavioral, and oral health as core developmental priorities for participating children. Nevertheless, interviews with health managers revealed concern that the health services area was perhaps a lower priority—reflected in budgets and staffing at the program level and messaging from OHS at the national level—as a result of the increased attention on school readiness in cognitive and socioemotional domains. Starting at the top, OHS could review its messaging regarding healthy child development to ensure that communications, training, and technical assistance clearly convey the importance of physical, mental and behavioral, and oral health as core building blocks for school readiness. That messaging can filter down to program directors, as well, who can then act to support health managers in their roles as they make decisions regarding budgets, staff, professional development, and so on. Responding to the implications already mentioned will also support the message that health matters.

Implications for the Role Information Could Play Moving Forward

One particular challenge of this study was the identification of the health manager workforce. While information is available for the program director in the PIR, similar information is not collected about the health manager or other key staff relevant to the health services area. Regularly collecting information in the PIR about the health manager—such as name, contact information, formal education and training, years of experience, and the number of sites the manager oversees—will open the door for future research about the health services area and will allow for cost savings, because sampling frames could be developed based on characteristics of the program or the health manager. Collecting this information also facilitates more-effective communication on the part of OHS, which could provide consistent messaging, resources, and

training directly to the health manager workforce, without routing through directors or regional offices.

Another potentially useful source of information is the set of geocoded characteristics that were assembled for this study to link with survey response and PIR data. Such data provide a context for understanding, at a more localized level, the health-related needs, resources, challenges, and opportunities facing HS/EHS programs. OHS should consider making such data more widely available for HS/EHS programs to utilize for purposes of planning, monitoring, and evaluation, as some programs do already. The geocoded information could also be used by OHS to target training, technical assistance, and other resources to HS/EHS programs based on the local contexts within which they operate.

Technical Working Group

We would like to thank the following members of the Head Start Health Manager Descriptive Study Technical Working Group. The views expressed in this publication do not necessarily reflect the views of these members.

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Abbreviations

AA	associate degree
AAPOR	American Association for Public Opinion Research
ACS	American Community Survey
ADD	attention deficit disorder
ADHD	attention deficit hyperactivity disorder
AIAN	American Indian and Alaska Native
BA	bachelor's degree
BMI	body mass index
CBP	County Business Patterns
CFR	*Code of Federal Regulations*
CPSC	Consumer Product Safety Commission
DHHS	U.S. Department of Health and Human Services
ECLKC	Early Childhood Learning and Knowledge Center
EHS	Early Head Start
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FQHC	Federally Qualified Health Center
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
HS	Head Start
HSAC	Health Services Advisory Committee

HS/EHS	Head Start and Early Head Start
IDEA	Individuals with Disabilities Education Act
IEF	income eligibility form
IEP	individualized education plan
IFPA	individual family partnership agreement
IFSP	individualized family service plan
IHP	individualized health plan
IHS	Indian Health Service
IMIL	*I Am Moving, I Am Learning*
IPEDS	Integrated Postsecondary Education Data System
IRB	institutional review board
LEA	local education agency
LPN	licensed practical nurse
MMIC™	Multimode Interviewing Capability
MOU	memorandum of understanding
MSHS	Migrant and Seasonal Head Start
OB	obstetrician
OCD	obsessive-compulsive disorder
OHS	Office of Head Start
OMB	Office of Management and Budget
PIR	Program Information Report
PTSD	posttraumatic stress disorder
RN	registered nurse

RWJF	Robert Wood Johnson Foundation
SCHIP	State Child Health Insurance Program
SDWIS	Safe Drinking Water Information System
SHAPES	Study of Healthy Activity and Eating Practices and Environments in Head Start
TANF	Temporary Assistance for Needy Families
TB	tuberculosis
TWG	Technical Working Group
U.S.C.	United States Code
USDA	U.S. Department of Agriculture
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
WONDER	Wide-ranging Online Data for Epidemiologic Research

1. Introduction

> *There is a lot that goes into being the health manager of a program because "health" encompasses all the components of Head Start. . . . In my experience working with other individuals in the health positions of Head Start for several years, the health component really is the largest component of the Head Start program.* —2012–2013 Head Start Health Manager Survey respondent

From its inception in 1965, the Head Start program has delivered early education and support services to low-income children ages three to five and their families. Head Start was an important initiative of the War on Poverty in the 1960s, fulfilling a need for a comprehensive and holistic preschool program for children at a socioeconomic disadvantage: This initiative would promote social and behavioral competence, ensuring that disadvantaged children enter school with a similar foundation as their more economically advantaged peers (Bitler and Karoly, 2015). Early Head Start, added in the 1994 Head Start Reauthorization Act, was initiated to provide a similarly comprehensive program of services to infants, toddlers, pregnant women, and their families. Migrant and Seasonal Head Start (MSHS) programs (also known as Region XII programs) serve children of low-income migrant or seasonal farmworkers. These programs operate at times when local harvesting is at its peak and the majority of children are dual-language learners. Head Start and Early Head Start (HS/EHS) programs serving American Indian and Alaska Native (AIAN) children (also known as Region XI programs) incorporate their unique history, community traditions, and beliefs into their programs' operation and provide an integration of language and culture into the delivery of services to children and families.

Throughout Head Start's nearly 50-year history, there has been broad recognition that the optimal development of the desired competencies for school readiness requires maximum health across all domains—a "healthy start" (Zigler and Muenchow, 1992). As a result, health was, and remains to this day, a core feature of HS/EHS programs. Indeed, promoting a child's physical development and health and social and emotional development are two of the featured domains in the *Head Start Early Learning Outcomes Framework* (Office of Head Start [OHS], 2015b), signaling the importance of child health in promoting optimal development leading to school readiness.

The long-standing emphasis on health in HS/EHS programs stems from a recognition by its architects—pediatricians Dr. Robert Cooke and Dr. Julius Richmond; child development experts Bettye Caldwell, Ph.D., and Edward Zigler, Ph.D.; and Sargent Shriver and Julie Sugarman from the Office of Economic Opportunity, among others—that early health forms a foundation for success in school and for later adult well-being (Zigler and Muenchow, 1992). Poor child health has both short- and long-term implications for school readiness and academic outcomes, yet many children enter kindergarten with poor health because of physical or emotional illness or limitations in their social, emotional, or physical development (High, 2008). Children with poor

health have higher rates of school absenteeism, more behavior problems, difficulty concentrating, lower performance on standardized tests, increased likelihood of repeating a grade, and higher enrollment in special education services (Leslie and Jamison, 1990; Behrman, 1996; Currie, 2005). A growing literature provides evidence of the linkages between health in the first few years of life and success in school and beyond. These linkages are further reinforced by evidence that early intervention, by supporting healthy development and school readiness, can generate long-term benefits in terms of adult health and other measures of well-being (Campbell et al., 2014).

At the same time, low-income children and their families, as well as low-income pregnant women and their families, face a number of health challenges. The Early Head Start Research and Evaluation Project found that 58 percent of the mothers in Early Head Start (EHS) programs and 18 percent of fathers scored above a clinical cutoff of depressive symptoms at the time of enrollment. In turn, children with depressed mothers were more likely to have behavior problems (O'Connor, Heron, and Glover, 2002), attention deficit hyperactivity disorder (ADHD), and mental disorders (Cummings and Davies, 1994). Children from families with low socioeconomic status were also more likely to experience poor growth in utero; premature birth; birth defects or disabilities (Wasserman et al., 1998; Vrijheid et al., 2000); asthma and other chronic conditions (Rosenbaum, 1992; Newacheck, 1994); higher blood lead levels (Starfield, 1982; Brody et al., 1994); and iron deficiency anemia, which may lead to shortened attention spans, fatigue, and difficulty concentrating (Parker, 1989; Starfield, 1989; Darmon and Drewnowski, 2008).

To assist each child in attaining his or her greatest possible physical, emotional, cognitive and social development, HS/EHS programs are regulated at the federal level through the Head Start Program Performance Standards (OHS, 2014). (See Appendix A for a summary of the relevant standards for the health services area of Head Start.[1]) Broadly, these performance standards require a determination of current health status; screening for developmental, sensory, and behavioral concerns; ongoing health care; family involvement and communication between staff and parents; consideration of health and safety issues; provision of nutrition services; and provision of individualized health services. Each local HS/EHS program independently determines how to plan for and implement these health-related services, and primary responsibility for doing so rests with the health manager (or health services manager). The health manager, together with other program staff, works with families, health care providers, and other community agencies and resources to help ensure that all children enrolled in HS/EHS have access to continuous health and dental care; have insurance; receive recommended age-appropriate primary and preventive health care and follow-up; receive health and developmental-

[1] Throughout this document and in Appendix A, we reference the Head Start performance standards in effect at the time of the data collection for this project. In mid-2015, the performance standards were in the process of being revised, with the aim of providing a reorganized and more streamlined set of standards that will shift Head Start from a compliance-oriented culture to an outcomes-oriented one (Administration for Children and Families, 2015a).

related screenings and follow-up; have access to mental health services as needed; and practice a wealth of health-promoting behaviors with children and families, including handwashing, toothbrushing, nutrition, physical activity, and safety. Health-related services are provided to pregnant women as well.

Rationale and Objectives for the Study

Despite the importance of Head Start's health services area, it is an often-overlooked aspect of the program. The last comprehensive report, *A Descriptive Study of the Head Start Health Component* (Keane et al., 1996), provided a focused examination of the Head Start health services area and the role of the health manager for a nationally representative sample of 81 centers across 40 Head Start (HS) programs.[2] Yet that information was collected in 1993–1995, more than two decades ago and prior to the implementation of Early Head Start. Further, the report included just one Head Start Region XI AIAN program, no Region XII MSHS programs, and no programs in Puerto Rico. Several recent studies have focused on specific topics in the health services area. These include the Head Start Oral Health Initiative Implementation Evaluation (Del Grasso, et al., 2008), the *I Am Moving, I Am Learning* Implementation Evaluation (Fox et al., 2010), the Study of Healthy Activity and Eating Practices and Environments in Head Start (SHAPES) (Whitaker, Gooze, et al., 2009), and the Pennsylvania Head Start Staff Wellness Survey (Whitaker, Becker, et al., 2013). The Family and Child Experience Survey (FACES) and Baby FACES address a wide range of topics, including health, but neither has the level of detail that the Health Manager Study addresses, nor have they included Region XI or XII programs (Office of Planning, Research, and Evaluation, undated-a, undated-b).[3]

[2] Interviews were conducted with 219 staff members in the programs or centers associated with the health services area, including health coordinators (42 interviews), nutrition coordinators (39 interviews), mental health coordinators (37 interviews), and parent-involvement coordinators (42 interviews). Center directors were also interviewed (59 interviews), and the budget manager completed a structured questionnaire. In addition, interviews were conducted with nearly 1,200 parents of four-year-old children participating in the sampled centers, and the health records of children in the sampled programs were reviewed.

[3] The first ever FACES data collection in Region XI AIAN Head Start programs was launched in fall 2015.

Terminology Used in the Report

Throughout this report, we rely on terminology regarding the Head Start program that is generally well-known but useful to clarify.

As is customary, we refer to ***Head Start*** as the federally funded program administered by DHHS, inclusive of the delivery of both Head Start and Early Head Start services.

Head Start grant awards are made to specific agencies or organizations, known as ***grantees*** or ***delegate agencies***. Separate awards are made to operate Head Start and Early Head Start. We refer to each award as a program, either an ***HS program*** or an ***EHS program***. We refer to all programs combined as ***HS/EHS programs***. A given agency or organization may simultaneously operate multiple Head Start grants, both HS programs and EHS programs.

Each HS or EHS program is classified into one of ten geographic-based ***Head Start regions*** (Regions I to X) or to one of two special regions (Region XI American Indian/Alaskan Native programs or Region XII Migrant and Seasonal Head Start programs).

Each HS or EHS program may operate multiple ***centers*** or ***sites***. Head Start and Early Head Start services may be provided in the same center or site.

Each HS or EHS program is administered by a ***director***. The same director may be associated with multiple programs.

Each HS or EHS program has a designated ***health manager*** responsible for the health services area. The position is also sometimes called the health services manager or health coordinator, among other titles. The same health manager may have responsibility for one or more HS programs and EHS programs.

HS/EHS programs provide data through the Head Start Program Information Reports (PIRs) on some aspects of the health of participating children and families and other such other aspects as health insurance coverage (see the text box for more detail). At the same time, the PIR is not designed to describe the breadth and depth of health services within local HS/EHS programs and how the staffing structure and community resources support the health services area. Currently, there are no other existing sources of information that would provide this level of detail for a representative group of HS/EHS programs. There is also a need to gain a deeper understanding of the processes that health mangers use to prioritize health topics for more-focused health initiatives; how they develop, select, and adapt curricula; and approaches they use to sustain such initiativesover time. Understanding how health mangers use national, state, and local data to monitor and prioritize health issues, and learning more about health mangers' decisionmaking processes with respect to the design and implementation of health services, is critically important for ensuring that the OHS is meeting the technical assistance needs of HS/EHS programs and their health managers in a way that is accessible, useful, and actionable.

Information in the PIR Related to the Health Services Area

OHS requires that its HS and EHS programs submit an annual PIR, which provides periodic updates on such topics as child and family demographics, services provided to children and families, and staff. In terms of the health services area, the PIR collects information related to physical health, oral health, mental health, and disabilities. The PIR contains the following indicators specific to **children** and measure the number

- with health insurance, as well as sources of coverage
- with an ongoing source of continuous accessible health care
- receiving medical services through the Indian Health Service (IHS)
- receiving medical services through a migrant community health center
- with an ongoing source of continuous accessible dental care
- who are underweight, healthy weight, overweight, or obese according to the body mass index (BMI)
- who are up-to-date on all age-appropriate immunizations, or with all available immunizations, or exempt from immunizations
- who are up-to-date on a schedule of age-appropriate preventive and primary health care and the number of those who were diagnosed with any chronic condition needing medical treatment, as well as the reason if treatment was not received
- who are receiving medical treatment for a list of specific chronic conditions
- who received preventive dental care, completed a professional dental examination, and were diagnosed as needing dental treatment, as well as the reason if treatment was not received
- who are up-to-date on a schedule of age-appropriate preventive and primary oral health care
- who were served by the program's mental health professional(s), who received specific types of mental health services and intensity of services, and who were referred for mental health services outside Head Start, as well as who received those services
- who had an Individualized Education Program (IEP) and type of diagnosed disability, and of those, who were determined eligible for special education and related services, and, of those, who did not receive the services
- who had an Individualized Family Service Plan (IFSP), and, of those, who were determined eligible for special education and related services, and, of those, who did not receive the services.

These indicators are specific to **pregnant women** and measure the number

- who are served by trimester when enrolled
- with health insurance, as well as sources of coverage
- who received specific medical services
- who received a professional dental examination or treatment.

These measures are specific to the **health services manager** and other staff in the health services area and capture

- the salary of health services manager and disability services manager and percentage funded by HS/EHS
- the hours per week that the health services manager and the disability services manager spend coordinating services
- the hours per month a mental health professional spends on-site.

The Head Start Health Manager Descriptive Study was designed to fill these gaps. The goals of the study were fourfold:

1. Describe the characteristics of health managers and related staff in HS/EHS programs.
2. Identify the current landscape of the Head Start health services area and what is being offered to children and families.
3. Determine how Head Start health initiatives are prioritized, implemented, and sustained.
4. Identify the programmatic features and policy levers that exist to support Head Start health services, including staffing, environment, and community collaboration.

In the remainder of this introductory chapter, we provide a brief description of the study approach and highlight other features of the study scope. We then describe the organizational framework that guided the study. Additional background is then provided on the health services area in Head Start, including the role of the health manager and other required elements, such as the Health Services Advisory Committee (HSAC). Readers familiar with the Head Start health services area and performance standards related to health may move directly to the final section of the chapter, which provides a road map for the rest of the report.

Study Approach

To achieve the four study goals listed above, we collected primary data using multiple modes: (1) an online survey that all HS/EHS directors were invited to take; (2) an online survey that all HS/EHS health managers referred to us by responding directors were invited to take; (3) semistructured interviews with a subset of HS/EHS health managers who responded to the online survey; and (4) semistructured interviews with a subset of HS/EHS teachers, family service workers, and home visitors referred to us by the interviewed health managers. HS/EHS programs in all ten Head Start geographic-based regions (Regions I to X), as well as Region XI AIAN programs and Region XII MSHS programs, were included in the surveys and interviews. These new data were combined with Head Start program administrative data from the Head Start PIR to fully characterize the health services area across the complete range of HS/EHS programs. We matched publicly available geocoded data to the survey data to provide additional contextual information about local health needs and health-related resources.

Given the nature of the study objectives, this work was designed to be descriptive, with the ability to capture the full range of experiences across HS/EHS programs in all regions on a broad set of topics, including the health issues the programs encounter; how they structure their health services area, including staffing; and their approaches to planning for and implementing health-related services and programs. The administration of the online survey for all HS/EHS programs in all regions ensured that varied experiences were reflected in the survey results. At the same time, the study did not seek to capture individual child or family data or to measure program compliance with respect to Head Start performance standards. In subsequent chapters, therefore,

we present results in aggregate or for subgroups in such a way that results for individual HS/EHS programs or staff cannot be identified.

The collection of new data also required a balance between the time respondents spent taking the survey and the depth of the information collected on any given topic. To ensure that respondent burden was reasonable, the online Health Manager Survey was not able to collect information from each respondent about the health services area in great depth across the wide range of topics the survey covered. Thus, the two sets of semistructured interviews—one with health managers and another with teachers, family service workers, and home visitors—were designed to allow for a more complete exploration of program approaches, successes, and challenges and thereby provide even greater insight into these issues than what could be learned in a more structured online survey. In sum, the combination of a broad-based structured survey of HS/EHS programs in all regions and a more in-depth semistructured interview format for a small group of stakeholders was designed to maximize the usefulness of the information collected.

Region XI AIAN and Region XII MSHS programs were included in the study to gain perspective on the health services area for all Head Start programs. Services for tribal communities and the children of migrant workers were established in 1965 and 1969, respectively (Office of Planning, Research, and Evaluation, 2004; Marks and Graham, 2004). In 1984, the American Indian Programs Branch and the Migrant Programs Branch were created, which later became the American Indian Alaska Native Region (Region XI) and Migrant and Seasonal Region (Region XII). Both programs share the same overall goals of Head Start while striving to meet the unique needs of the children and families they serve. Most AIAN HS/EHS programs are on reservations, often in rural or remote communities, and administered by sovereign nations. Programs are tailored to respond to the cultural and linguistic context within each tribal community. MSHS programs are designed around the geographical movement of agricultural farmworkers, and accordingly programs may be open only for certain months of the year to match the agricultural work. Often, a centrally located MSHS grantee administers (directly or through a delegate agency) a geographically dispersed set of program sites, sometimes crossing county or even state boundaries. From inception, MSHS programs have been serving children from birth to kindergarten entry, long before Early Head Start was introduced. Despite their long histories, both AIAN and MSHS programs are relatively understudied.

Given the study objectives and the breadth of the topics required to achieve them, we did not pursue in-depth data collection on all aspects of health in the context of Head Start, such as the health issues and needs facing individual children and families served by HS/EHS programs. Thus, for example, the study was not designed to measure the incidence of specific physical, behavioral, mental, or oral health conditions in the population of HS/EHS children or their families. These are issues that can be examined with other sources of information, such as some of the measures collected in the PIR or through other focused studies of HS/EHS children and families (e.g., FACES and Baby FACES). At the same time, to provide context for

understanding the provision of health-related services and programming in Head Start, our data-collection efforts did include questions to ascertain the child and adult health issues that were of greatest concern to health managers.

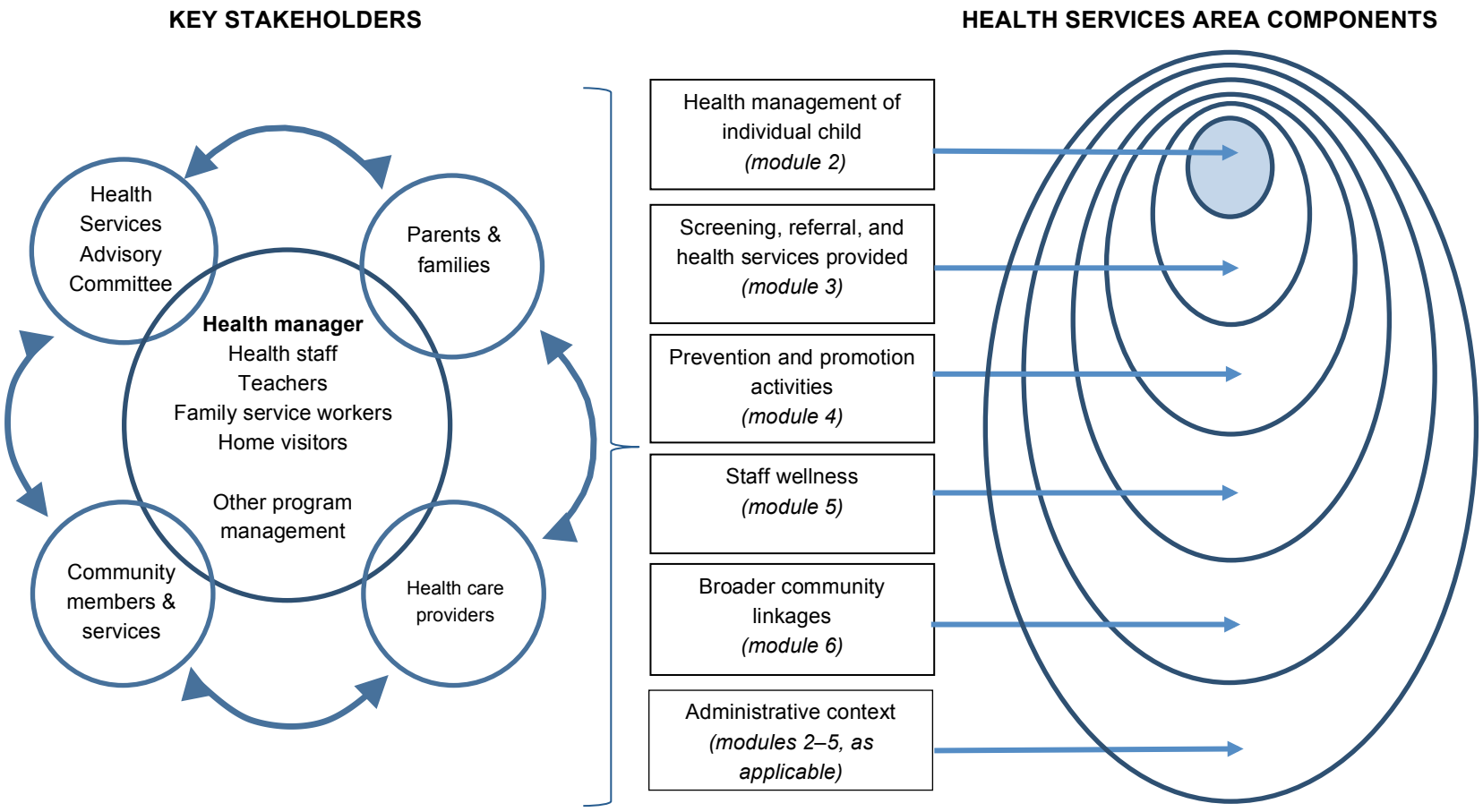
In sum, the descriptive information collected for this study is designed to provide a richer understanding of the entire range of strategies employed by HS/EHS programs in the health services area, the ways in which programs are succeeding, and the issues that are challenging to address. Such insights, coupled with detailed information on programmatic features and policy levers that exist to support such services, should provide OHS and other stakeholders with a wealth of information that can help to shape technical assistance to promote the health of HS/EHS children and families, inform decisions about programmatic improvement, and identify information gaps to be addressed in future data-collection efforts.

Organizational Framework

This study was guided by an organizational framework that is shaped by an understanding of the key stakeholders involved in planning for, implementing, and participating in the Head Start health services area, as well as the Head Start performance standards in the health services area (see Figure 1.1). As shown on the left side of the figure, at the center of the health services area is the health manager and other program staff (e.g., teachers; family service workers; home visitors; and other program managers, such as the program director) who plan for and implement the health services area. The core health-related HS/EHS staff interact with four other key sets of stakeholders: the HSAC, the parents and families of participating children, the health care providers in the local community, and other local community members and service providers. The arrows in the figure further convey that there are interactions between all the stakeholder groups, in addition to those facilitated by HS/EHS programs.

The right side of the figure illustrates the cascading set of activities that emerge from the performance standards—activities that engage the various stakeholders shown on the left side of the figure. At the core of the health services area is the management of the health needs of each individual child. Those needs in turn are met by a series of health-related activities that include health screenings, health referrals, and the provision of health services, as well as prevention and health-promotion activities delivered to participating children and their families. At the next level, the health activities broaden to include support for the wellness of HS/EHS staff. Next, the linkages to the broader community of health providers and health-related services expand the resources available to HS/EHS children and families. Finally, the outermost level is intended to capture the range of administrative functions in HS/EHS programs that support the nested set of health services area activities. As discussed in Chapter Two, the structure and content of the data-collection instruments are shaped by this organizational framework.

Figure 1.1. Study Organizational Framework



NOTES: The figure does not show modules 1 and 7, which covered topics related to the staffing model and management structure of the health services area; professional development; the HSAC; and the health manager's demographics, education, training, and experience.

The framework in Figure 1.1 provides a mechanism by which to conceptualize the wide-ranging components and activities of the Head Start health services area. Although each program is likely to conduct at least some activities related to each aspect, or level, of the framework, we assume that the relative emphasis will vary by program based on the needs of the population served and the available internal and external resources.

Health Services Area in Head Start

As articulated in the *Head Start Early Learning Outcomes Framework* (OHS, 2015b)—a document designed to guide programs in their curriculum and assessment decisions—the developmental building blocks that support school readiness include two key domains: (1) perceptual, motor, and physical development and (2) social and emotional development. The former domain includes health, safety, and nutrition. The latter domain incorporates aspects of emotional and behavioral health, including a developmentally appropriate range of emotional expression and the ability to regulate emotions and adapt to new environments. These two health-related domains, together with three other overarching areas of development, are viewed as the key child development and early learning domains that are linked to children's success in school and beyond.

The Head Start Program Performance Standards, published in the *Code of Federal Regulations* (45 CFR 1301–1311), detail more than 100 requirements with respect to the health services area (OHS, 2014) (see Appendix A).[1] Below we highlight several key requirements and also note other performance standards pertaining to the health of pregnant women (45 CFR 1204.40(c)), which are relevant for EHS programs in particular.

Health and Developmental Services

CFR 1304.20 and other related standards outline the child health and developmental services. These include determining a child's current health status within 90 days of enrollment—such as whether the child is up-to-date on preventive and primary care (including immunizations) and has access to a continuous source of care—and developing and implementing a plan to follow up on any identified health needs, as well as screening for developmental, sensory, and behavioral concerns. Beyond the 90 days of enrollment, the grantee must

- facilitate follow-up and treatment by providing assistance, as needed, to families seeking or paying for care and managing their children's health conditions
- implement procedures to ensure ongoing and routine care and preventive services
- educate and involve parents in all decisions related to their children's health

[1] One source (Office of Planning, Research, and Evaluation, 2012) cites 179 performance standards related to health, nutrition, mental health, and safety. Depending on which standards are considered applicable and how standards are counted, the number could be smaller or larger.

- individualize the program to maximally support each child, based on his or her strengths and special needs.

Health and Safety

The child health and safety performance standards (CFR 1304.22 and elsewhere) specify requirements for health emergency procedures; the standards describe policies and plans of action in the event of an emergency; conditions of short-term exclusion and admittance to minimize risk to the health and safety of other children or staff; written procedures and policies about medication handling and administration; injury prevention and safety awareness; hygiene; and the existence of readily available, fully stocked first aid kits.

Child Nutrition

CFR 1304.23 outlines child nutrition requirements, including the identification of nutritional needs; the provision of nutritional services that meet the daily nutritional needs of children, while being cognizant of individual dietary and family cultural food preferences and requirements; meal services that promote the development and socialization of children, while exposing children to new food experiences; educating and developing relevant skills for families around nutrition and healthy-food preparation; and food safety and sanitation practices compliant with all federal, state, tribal, and local food safety and sanitation laws.

Mental Health

CFR 1304.24 specifies requirements regarding child mental health, including working collaboratively with parents to identify child mental health concerns and appropriate courses of action; securing the services of mental health professionals to assist in the timely identification of mental health concerns; and the provision of regular, on-site mental health consultations to assist staff and parents in the support of children and to identify additional community resources, if needed.

Services to Pregnant Women

CFR 1304.40(c) notes that EHS grantee and delegate agencies must assist pregnant women in accessing comprehensive prenatal and postpartum care, which must include risk assessments (e.g., assessment of nutritional counseling), health promotion and treatment (e.g., medical and dental examinations), and mental health interventions (e.g., substance abuse prevention and treatment). Programs must also provide prenatal education about fetal developmental, labor and delivery, and postpartum recovery, as well as information about the benefits of breast-feeding.

Education and Early Child Development

CFR 1304.21 (among other standards) outlines the requirements for education and early childhood development. These include having an approach for child development and education that is developmentally and linguistically appropriate and that takes into account individual differences and encourages parent feedback and engagement; supporting social and emotional development of children through their routines, transitions, and interactions with adults and other children in the center; providing for the development of cognitive and language skills; and promoting physical development through play.

Health Manager, Staff, and Health Services Advisory Committee

To provide these services, every HS/EHS program is required to have qualified staff—typically called the health manager—responsible for managing, facilitating, and coordinating health services that promote health, development, nutrition, and mental health among enrolled children (CFR 1304.52). Nutrition, mental health services, and disability services must be supported by either staff or consultants with specific expertise. In addition, the health manager supervises other HS/EHS staff as they perform health-related duties and is responsible for maintaining, monitoring, tracking, overseeing, and ensuring the confidentiality of health records. Depending on the health manager's education background, credentials, and experience, he or she may or may not provide direct services. Depending on the size and staffing model of the program, the health manager may directly supervise health staff and other consultants who support the program (e.g., health consultant, nutrition consultant, or mental health consultant).

The Head Start Program Performance Standards (CFR 1304.41) also require HS/EHS grantee agencies to have an HSAC that brings together staff, parents, local health care providers, community members, and staff from agencies serving the same population (e.g., staff from the state Early and Periodic Screening, Diagnostic and Treatment [EPSDT] program and the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]). The HSAC serves as an advisory committee, an advocacy body, and a resource for health education and training within the program. The HSAC can also provide technical expertise, participate in annual self-assessments of program effectiveness, establish short- and long-term goals and objectives to best meet the needs of children and families in the community, and serve as a linkage to other community partners.

In addition to the HSAC, the performance standards (CFR 1304.41) require HS/EHS programs to assist parents with the establishment and maintenance of community linkages to care. Notably, in 1993, the Advisory Committee on Head Start Quality and Expansion recommended the establishment and expansion of community linkages to benefit HS/EHS families and children (DHHS, 1993; see also Office of Planning, Research, and Evaluation, 2012).

Nature of the Performance Standards

A review of the specific health- and safety-related performance standards compiled in Appendix A reveals several features of the standards. As noted, the standards are numerous, both those that have direct bearing on the health services area and those that are more indirectly related (e.g., through standards focused on other aspects of child development).

In many cases, the standards are very prescriptive, with precise requirements that programs are expected to follow. For instance, within 90 calendar days of the first day that Early Head Start or Head Start services are provided to the child, the programs must determine whether a child has a medical and dental home; determine whether a child is up-to-date on the schedule of age-appropriate preventive and primary health care, which includes medical, dental, and mental health; obtain or arrange for further testing, examination, or treatment for any identified health or developmental problem; and develop and implement a follow-up plan for any identified conditions (CFR 1304.20(a)(1)). In addition, linguistically and age-appropriate screening "regarding a child's developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual, and emotional skills" must be performed or obtained within 45 calendar days of entry (CFR 1304.20(b)(1)).

At the same time, other standards are more general and provide HS/EHS administrators and health managers with flexibility in how the requirements will be met. For example, programs must "establish procedures to track the provision of health services" (CFR 1304.20(a)(1)(ii)(C)), but those procedures are up to the program to determine. Standards pertaining to involving parents specify that programs must "encourage parents to be active partners in their children's health care processes" (CFR 1304.20(e)(4)), but the strategies for parent engagement are not delineated. In terms of staffing, the health services area must be "supported by staff or consultants with training and experience in public health, nursing, health education, maternal and child health, or health administration" (CFR 1304.52(d)(2)), but the staff configuration is not dictated, rather "agencies must determine the appropriate staffing pattern necessary to provide these functions" (CFR 1304.52(d)).

Other standards involve terms that may be subject to interpretation, such as the definition of "an ongoing source of continuous, accessible health care" (CFR 1304.20(a)(1)(i)). The PIR, in asking programs to record the number of children with a medical home at the time of enrollment and at the end of the program year, notes that the concept of a medical home excludes urgent care centers and emergency room settings. The features that otherwise make a provider relationship "continuous" and "accessible" are not clear. Another example is the requirement that programs, in collaboration with parents, must implement a curriculum that "integrates all educational aspects of the health, nutrition, and mental health services into program activities" (CFR 1304.21(c)(1)(iii)). In this case, it is not evident whether the word *all* references the totality of the potential health services area or just those areas that have been identified as priority topics. In the case of parent involvement in these topics, the standards provide a little more specificity:

> *Grantee and delegate agencies must ensure that, at a minimum, the medical and dental health education program . . . provides parents with the opportunity to learn the principles of preventive medical and dental health, emergency first-aid, occupational and environmental hazards, and safety practices for use in the classroom and in the home. In addition to information on general topics (e.g., maternal and child health and the prevention of Sudden Infant Death Syndrome), information specific to the health needs of individual children must also be made available to the extent possible.* (CFR 1304.40(f)(2)(iii))

Another standard with room for interpretation is the requirement that programs develop a plan for implementing services, including health services, to address the findings of the community assessment (CFR 1304.51(a)(1)). The linkage between findings from the assessment and appropriate activities or services provides programs and their health managers with considerable scope for interpretation and appropriate implementation.

Finally, it is important to note that some of the health-related performance standards are reinforced through the information collected in the PIR (see the " Information in the PIR Related to the Health Services Area" box earlier in the chapter), such as providing counts of the children with a medical or dental home, children with insurance coverage, children who are up-to-date on immunizations and preventive and primary oral health care, and children with specific diagnoses who did and did not receive treatment.

Road Map for the Report

The Head Start Health Manager Descriptive Study provides essential information about the Head Start health services area in a systematic way. We begin in Chapter Two with information about the study methods, including our approach to the online survey of HS/EHS directors and health managers and the semistructured interviews with a small number of HS/EHS health managers, teachers, family service workers, and home visitors. We also discuss our use of Head Start administrative data and geocoded data matched to the survey responses.

Next, Chapters Three to Fifteen present findings from the survey and interviews, organized by key themes that flow from our organizational framework (see Figure 1.1), which allows the interested reader to quickly access material that is most relevant (e.g., in Chapters Nine to Eleven, parallel information is presented separately for physical health, behavioral health and oral health):

- characteristics of the health manager workforce (Chapter Three)
- approaches to staffing and professional development for the health services area (Chapter Four)
- the HSAC and policies for the health services area (Chapter Five)
- health issues for HS/EHS children and families (Chapter Six)
- health management of the individual child and communications (Chapter Seven)
- components of health services in Head Start (Chapter Eight)
- coordination of physical health services in Head Start (Chapter Nine)

- coordination of behavioral and mental health services in Head Start (Chapter Ten)
- coordination of oral health services in Head Start (Chapter Eleven)
- informing, prioritizing, implementing, and monitoring health-promotion activities in Head Start (Chapter Twelve)
- community partnerships in the Head Start health services area (Chapter Thirteen)
- funding for the health services area (Chapter Fourteen)
- crosscutting issues (Chapter Fifteen).

Additional analyses draw on data from the PIR and the geocoded data links to the survey responses. A final chapter summarizes the key findings and presents implications for OHS and other stakeholders. A series of technical appendixes provide more in-depth information regarding the data-collection methods, present the survey instruments and interview protocols, and provide supplemental tabulations.

2. Study Methods

This chapter details the methods used to collect and analyze the primary and secondary data presented in the remainder of the report. We begin with a brief overview of the quantitative and qualitative data-collection components and the integration of other sources of data into our analyses—specifically, Head Start administrative data from the PIR and geocoded data assembled for the study. Next, we describe the collection of the online survey data, with information on questionnaire design, fielding the survey, and response rates. The approach to data analysis is discussed as well. We then provide equivalent information for the qualitative data collection through semistructured interviews. A final section describes the geocoded data assembled for the study.

Additional detail about methods is provided in Appendix B for the online surveys and Appendix C for the semistructured interviews. Appendix D contains the online survey instruments, while Appendix E has the interview protocols. Additional detail on the geocoded data is provided in Appendix F.

Overview of Approach to Quantitative and Qualitative Data Collection

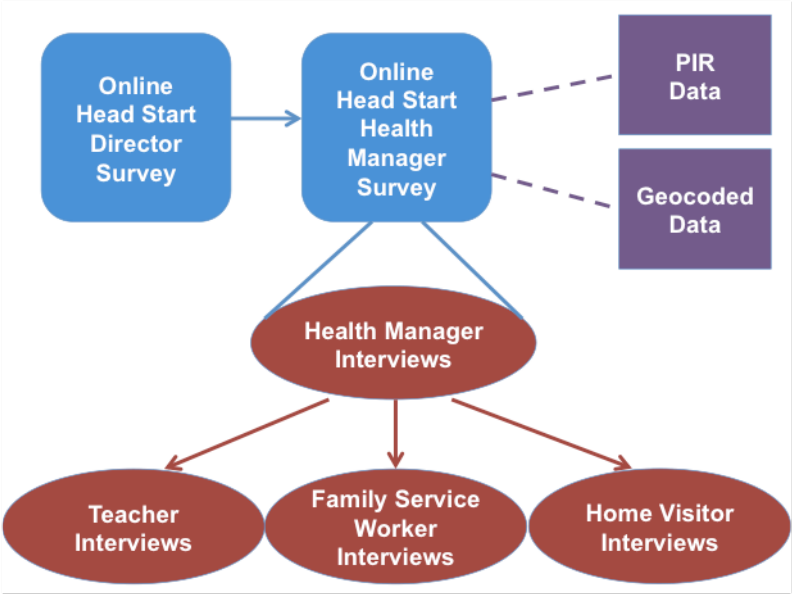
This study integrated both primary and secondary data using multiple methods, so we begin with an overview of the various data components employed in the study. This study also aimed to be inclusive of Region XI AIAN and Region XII MSHS programs, two components of Head Start that were not included systematically in the last descriptive study of the Head Start health services area. Given this special focus, we also provide an overview of our approach to the inclusion of programs from these two Head Start regions.

Data Components

Figure 2.1 illustrates the relationship between the various data components in the study. In particular, primary data collection involved two online surveys (blue boxes) and two sets of semistructured interviews (red ovals).

- Head Start Director Survey. Based on contact information available in the 2011–12 Head Start PIR, all directors for HS/EHS programs (i.e., grantees and delegate agencies) including Region XI AIAN grantees and Region XII MSHS grantees—were invited to complete a short online survey to obtain basic information about the HS/EHS program, their role in key activities in the health services area, and the health services area budget. The director was also asked to provide the name and contact information (i.e., email address) for the health manager or health managers in their program.

Figure 2.1. Relationship of Study Data Components



- Head Start Health Manager Survey. All health managers for HS/EHS programs were potentially eligible to complete an online survey, although survey invitations were extended only to those for whom their directors provided contact information. The Health Manager Survey questionnaire covered more-detailed information about the health manager and that role, the role of other HS/EHS staff, and the various components of the health services area. The survey instrument included core questions administered to all respondents and a set of supplemental questions, divided into four modules. Respondents were stratified and then randomly assigned to respond to one of the four supplements, so about one-quarter of the respondents answered each set of supplemental questions.
- Health manager interviews. In order to obtain more in-depth information not possible with a structured survey questionnaire, a purposive sample of health managers who completed the online survey was invited to participate in a semistructured telephone interview to probe more deeply into the topics covered by the online survey. We had a goal of 40 interviews, so we selected the respondents to ensure that the sample captured variation along key HS/EHS program features.
- Teacher, family service worker, and home visitor interviews. In recognition of the important role played by other HS/EHS staff in the delivery of the health services area, the health managers selected for the interview were asked to nominate teachers, family service workers, and home visitors in their programs who might be willing to be interviewed. Those individuals were then invited to complete a semistructured telephone

interview so we could learn more about their roles in the provision of the health services area. The goal was to achieve 60 interviews in total.

As shown in Figure 2.1, the survey and interview data are linked to two sources of secondary information. First, administrative data from the PIR are linked to each HS/EHS grantee or delegate agency represented in the survey and interview data. The ability to link to the PIR allowed the online survey to complement, not duplicate, information already collected from HS/EHS programs. Second, the study involved the identification and compilation of publicly available geocoded data sets relevant to Head Start and the health services area. Such data provide additional contextual information from which to characterize the health needs and resources in the communities where HS/EHS programs operate.

As required under the 1980 Paperwork Reduction Act, the study protocol was reviewed and approved by the Office of Management and Budget (OMB) (OMB approval number 0970-0415). Likewise, the study was reviewed by RAND's institutional review board (IRB) to ensure that that all requirements for the treatment of human subjects in research were met. No incentives were offered for the completion of the online surveys or the interviews.

Approach to Inclusion of Region XI AIAN Programs

According to Head Start administrative data, Head Start served more than 41,000 AIAN children and pregnant women during the 2012–2013 program year. Nearly half of that population (48 percent) was served through Region XI AIAN programs, where the vast majority (86 percent) of enrolled children and pregnant women identify themselves as American Indian or Alaskan Natives. In that same year, compared with the number of AIAN children served in Region XI AIAN programs, Head Start served slightly more AIAN children and pregnant women as part of programs in the geographic-based regions (Regions I to X), as well as Region XII MSHS programs.

The Head Start Health Manager Descriptive Study is the first nationally representative survey of HS/EHS programs to include AIAN programs from Region XI. To be fully inclusive of programs serving AIAN populations, the RAND study team, together with the Administration for Children and Families, OHS, and the project Technical Working Group (TWG), took great care to ensure that the ways in which the study was designed, approved, and launched accounted for and was respectful of tribal culture and history around research with tribal populations. These steps included

- TWG representation. A member of the study TWG had extensive experience working with AIAN communities and helped develop the study notification and approval process among tribal nations.
- Cognitive interviews with health managers. When survey instruments were being developed, the study team conducted cognitive interviews with nine health managers to

receive feedback. Two of the nine health managers who participated in the cognitive interviews worked in Region XI AIAN programs.

- IHS involvement. The study team worked closely with IHS staff to develop a plan for notifying tribal leaders about the study and for obtaining human subjects approval through the national IHS IRB and all regional IHS IRBs.
- Tribal IRB approvals. IRB approval was sought and received from the IHS board, as well as all nine regional boards in existence at the time of this study and four independent tribal IRBs. Four additional independent tribal IRBs reviewed the study and determined that they did not have relevant oversight (e.g., IRB was for research occurring with a college or university). Two tribal IRBs did not provide approval for the study.
- Tribal leader notification. A study package was sent to all tribal chairpersons affiliated with a Region XI HS/EHS program. This package was mailed to more than 200 tribal leaders and included a cover letter, detailed study summary specific to Region XI grantees, and a letter from the Head Start director. Packages were not sent to tribal leaders of the two tribes from which we did not receive IRB approval.
- Region XI expert panel. A six-member expert panel of AIAN representatives reviewed and commented on the planned analyses and the documentation of the results. The panel representatives included individuals in such positions as HS/EHS director, health manager, tribal IRB co-chair, National Indian Head Start Directors Association board member, tribal education program administrator, and academic researcher.
- Tribal IRB review of study reports. The final draft study report was distributed to all tribal IRBs that gave approval for the study to provide for a period of review and comment. This review process was a requirement for a subset of the tribal IRBs and the IHS IRB.

In the chapters that follow, when survey results are presented for questions from the Director Survey or core questions from the Health Manger Survey, results are displayed separately for Region XI AIAN programs. Results are always presented in aggregate so that no specific program, tribe, or nation will be identifiable.

It is important to keep in mind that the results for Region XI AIAN programs provide insights for programs that reach about one-half of all the AIAN children and pregnant women served by Head Start. The remaining AIAN population served by Head Start is distributed across programs administered through the other Head Start regions.

Approach to Inclusion of Region XII MSHS Programs

Attention was given to the inclusion of Region XII MSHS programs, although the additional IRB approvals described above for Region XI AIAN programs were not required. In designing the data-collection instructions and protocols, the RAND team, together with the Administration for

Children and Families, worked to ensure that the unique circumstances of MSHS programs would be captured. This was accomplished by having expertise with Head Start MSHS programs on the TWG and by consulting with MSHS experts within OHS during the development of the survey instruments and interview protocols. These same experts reviewed the draft report and findings. In the design phase, cognitive interviews were conducted with health managers from MSHS programs to ensure that the survey instrument wording and response options were relevant for the MSHS program context.

Online Survey Methods and Response Rate

The online Director Survey and Health Manager Survey were the central data-collection components of the study. In this section, we first discuss the design and content of the two survey questionnaires. We then describe how the data collection took place and the number of survey respondents and response rates. Additional information on the survey methods and response rates is provided in Appendix B.

Questionnaire Design and Content

The primary objective of the Director Survey (included in Appendix D) was to obtain a referral to the program's health manager, given that there was no central database with contact information for HS/EHS program health managers. In addition, the Director Survey provided information on topics specific to directors' role within the health services area or where they would likely be the best informant. Thus, the questions covered the director's role with the HSAC; the overall budget and budget for the health services area; and the director's education, training, and demographic characteristics. When directors had responsibility for more than one program (e.g., an HS program and an EHS program), they were allowed to nominate more than one health manager. The questions about directors' role with the HSAC and the budgetary questions were specific to each grant.

For the Health Manger Survey, there was interest in covering a broader set of topics related to the study framework (see Figure 1.1). Input was obtained from TWG members and the Administration for Children and Families (OHS; Office of Planning, Research, and Evaluation; and the Office of the Deputy Assistant Secretary and Interdepartment Liaison for Early Childhood Development) regarding specific topics to cover within the domains included in the study framework. As a first principle, in designing the questionnaire, there was an effort to avoid collecting information already available in the PIR (e.g., program type, enrollment, demographic characteristics of children and families served, health insurance coverage), given the expectation of being able to match the survey data to the PIR data. For those topics not covered by the PIR, where possible, we looked to other surveys for questionnaire wording and response codes. Examples of surveys that served as a source of questionnaire items included the 1993–1995 Descriptive Study of Head Start Health Services (Keane et al., 1996), the Early Childhood

Longitudinal Study (National Center for Education Statistics, undated-a), FACES and Baby FACES (Office of Planning, Research, and Evaluation, undated-a, undated-b), the Survey of Early Head Start Programs (Office of Planning, Research, and Evaluation, 2005), the Migrant and Seasonal Head Start Research Design Development Project (Office of Planning, Research, and Evaluation, 2004), and the Florida Head Start State Survey (Florida Institute of Education, 2010). Questions that could be used in the same format allowed for the possibility of comparability across data sources and over time. However, in most cases, question wording and response codes had to be modified to be more relevant for the study objectives. Such changes to the question wording and response categories were informed by nine cognitive interviews with health managers serving a diverse mix of program types (including Region XI AIAN and Region XII MSHS programs), as well as input from the TWG.

The resulting Health Manager Survey instrument (included in Appendix D and displayed graphically in Figure 1.1) was structured around seven modules, with the following content aligned to the study framework:

- Module 1 and module 7 are focused on health managers, the HSAC, the staffing model and management structure of the health services area, and professional development. Module 7 contains additional questions about the health manager's demographic background.
- Module 2 is focused on understanding the breadth and prevalence of health conditions among the HS/EHS population, the effort undertaken by HS/EHS staff in regular management of those conditions, and communication strategies with parents or guardians about specific health concerns regarding a child.
- Module 3 is designed to describe the screening and referral processes of HS/EHS programs, including linkages with health providers in the community and availability of regular sources of care, with subsections pertaining to physical health services, behavioral and mental health services, and oral health services.
- Module 4 is focused on HS/EHS program activities in the areas of health promotion and disease prevention, including topic selection and prioritization, implementation challenges, other family health-promotion activities and the influence of state or local policies on such activities.
- Module 5 covers the HS/EHS program activities to support staff wellness.
- Module 6 is designed to capture the network of health-related community partners (along with physical, behavioral, mental, or oral health providers) that support health activities in HS/EHS programs, as well as community engagement strategies undertaken by programs.

The broader administrative context (e.g., follow-up, funding, monitoring) is assessed in modules 2–5, where applicable. Some of these questions are also included in the Director Survey.

To further reduce the burden on health manager respondents, we divided the Health Manager Survey instrument into a set of core questions administered to all respondents and purposefully selected supplemental questions to be administered to a stratified random subset of respondents. Table 2.1 shows the division of questions by core and supplement across the major areas of the survey and their associated modules. The 118 survey questions were evenly divided between the core instrument and the supplement. The number of questions in each supplement varied slightly but were balanced according to the complexity of the question, so that the administration time for each supplement would be approximately the same.

Table 2.1. Number of Core and Supplement Survey Items in the Health Manager Survey Instrument, by Module

		Core	Supplement	
Module	Topic	Number of Questions	Number of Questions	Section
1	Staff structure, responsibilities, and competencies	9	3	A
1	Training and professional development	3	1	A
1	HSAC	7	4	A
1	Program policies	0	5	A
2	Health management of individual child	4	7	B
3	Screening, referral, and health services provided	14	18	C, D
4	Disease-prevention and health-promotion activities	5	12	D
5	Staff wellness	0	3	B
6	Broader community linkages	2	4	A
7	Health manager background	15	2	B
	Total	59	59	

The supplemental questions were divided into four groups, labeled Supplement A, Supplement B, Supplement C, and Supplement D. Supplemental questions in the same module (or subsection) were grouped together to maintain the flow of the instrument (a feasible approach with an online instrument). By administering supplemental questions in a given module together, responses across questions on the same topic could be analyzed together for the random subset of respondents who answered those questions.

Respondents were stratified and randomly assigned to one of the four supplements. So the questions in each supplement were answered by approximately 25 percent of the respondents. The strata, based on information in the PIR, were defined as follows:

- special-population program (Region XI, Region XII, and all other regions)
- program type (EHS program only, EHS program and HS program, or HS program only)
- program size of grantee or delegate agency (three levels, defined as up to 150 slots, 151 to 349 slots, and 350 slots or more)

- percentage dual-language learners (three levels, defined as 0 to 5 percent, 5 to 30 percent, and 30 percent or more).

The stratification ensured that, for each supplement, we had representation of respondents across Head Start regions, program type, program size, and language status. However, given the smaller number of respondents to the supplements, we do not report results separately for each of these strata.

As noted below, health managers may be responsible for more than one program (e.g., an HS program and an EHS program). In such cases, health managers responding to the Health Manager Survey were reporting on the combined features of the programs they were responsible for. In other words, questions were not specific to each program but rather pertained to the totality of the programs that health managers were responsible for.

Fielding the Survey

For the Director Survey and Health Manager Survey, the primary mode of data collection was web-based and administered using RAND's Multimode Interviewing Capability (MMIC™) survey system, a computer-assisted data-collection program. Respondents using the MMIC interface were given a unique login and password, so the status of their survey could be tracked. Respondents were able to begin the survey online, save responses, and return later to the instrument if they were not able to complete the survey in one session. MMIC also offered a "help desk," which provided technical assistance for respondents through a toll-free number and an actively monitored email account. At the conclusion of the survey, MMIC allowed respondents to download and print their complete sets of responses. Those who were not able to complete the survey using one of the available electronic methods (e.g., Internet, smart phone) were offered the opportunity to conduct the survey over the telephone with a trained interviewer. Virtually all respondents elected to complete the survey online. Respondents for both the Director Survey and the Health Manager Survey were also provided an opportunity to conduct the interview by phone in Spanish if that was their preferred language.

For the two online surveys, the frame of eligible HS/EHS programs was identified through the Head Start PIR. As of November 2012, there were 2,834 HS/EHS grantee and delegate agencies with active enrollment in Regions I through XII.[5] The PIR was used to obtain the email address for the program director for each grantee or delegate agency. The records were reviewed to identify the set of unique directors, as some directors were responsible for multiple programs (e.g., typically for an HS program and an EHS program).

Starting in mid-December 2012, all directors, with the exception of Region XI directors, where the IRB clearance process was still under way, were invited to complete the online Director Survey. Each director was contacted by email with a short description of the study and a

[5] There were 35 grantee records in the PIR that showed no current enrollment. Those grantees were not included in the survey frame.

letter of support from the director of the Office of Head Start. The email contained a link to the survey home page, and directors were given a unique ID and login password to launch the survey. Follow-up for those who did not respond or whose survey was not complete was conducted by email, as well as by phone, throughout the survey's field period. Once the tribal IRB clearance process was completed in mid-June 2013, directors for Region XI AIAN programs were also invited to complete the Director Survey. The Director Survey remained open through October 2013.

As directors completed their surveys, the contact information they provided for one or more health managers was used to invite them to complete the online Health Manager survey.[6] As with the Director Survey, each health manager received an email with an invitation to participate in the study, accompanied by information about the project and a letter of support from the director of the Office of Head Start. The survey ID for each health manager was linked to the ID for his or her referring director, so their survey responses could be linked. Follow-up with health manager who had not responded to the survey occurred by email and phone throughout the field period. The first health manager invitations were sent out in mid-January 2013 and continued on a weekly basis; all health managers identified by directors in a given week were issued an invitation to participate in the study at the start of the following week. The Health Manager survey was open for responses through November 2013.

Response Rate

Table 2.2 shows the responses for the Director Survey and the Health Manager Survey in reference to all HS/EHS programs in the survey frame. As of November 2012, the number of HS/EHS programs consisted of 2,834 HS/EHS grantees or delegate agencies. Fifty of those programs closed during field period (the 2012–2013 program year) and were therefore excluded from the frame. Another six programs were excluded because we did not receive IRB approval. Thus, a total of 2,778 HS/EHS programs were eligible for the survey during the field period.

The PIR data showed 1,965 unique directors associated with the 2,778 programs, and each director was invited to complete the Director Survey and make a referral to his or her health manager(s). Six directors did not consent to the survey, and 332 did not respond during the field period, for a total nonresponse of 338 directors. The remaining directors either completed the full survey (1,436 directors) or a partial survey that at least provided a health manager referral (191 directors). Thus, the response rate (including partial responses) for the Director Survey was 83 percent (1,627 out of 1,965 directors).[7] Since some directors responded for more than one

[6] Beginning in June 2013, if the director had provided a referral for one or more health managers who had not returned to complete the survey in more than four weeks, the Director Survey was closed and a survey invitation was sent out for the health managers. Invitations to health managers identified in otherwise incomplete Director Surveys continued on a rolling basis until the end of the field period.

[7] This response rate corresponds to the American Association for Public Opinion Research (AAPOR) response rate 4 (AAPOR, 2015). See Appendix B for additional detail.

program, the 1,627 directors represented 2,330 programs, or 84 percent of eligible HS/EHS programs.

Table 2.2. Online Director Survey and Health Manager Survey Response Outcomes

Measure	Universe of HS/EHS Programs	Survey Respondents	
		Directors	Health Managers
HS/EHS grantee and delegate agencies as of November 2012	2,834		
Closed during 2012–2013 year	50		
Did not obtain IRB approval to survey	6		
HS/EHS grantee and delegate agencies eligible for survey	2,778		
Unique directors invited to complete survey		1,965	
Director did not consent to survey		6	
Director did not respond		332	
Total nonresponse		338	
Director completed survey (partial)		191	
Director completed survey		1,436	
Total director response	2,330	1,627	
Unique health managers referred by directors invited to complete survey			2,013
Health manager did not consent to survey			23
Health manager did not respond			525
Total nonresponse			548
Health manager completed survey (partial)			124
Health manager completed survey			1,341
Total health manager response	1,902		1,465

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey and Health Manager Survey.
NOTE: Results are unweighted.

The final column of Table 2.2 shows that the 1,627 directors made referrals to 2,013 unique health managers, who were then invited to complete the Health Manager Survey.[1] Of that group, the total nonresponse was 548 cases: 23 health managers did not consent, and the remaining 525 did not respond. A partial survey was received from 124 health managers, and 1,341 health managers completed the full online survey. Thus, the response rate for the Health Manager Survey, including the partial respondents, was 73 percent (1,465 out of 2,013).[2] Although some health managers serve one program, others serve two or more programs (e.g., an HS program and EHS program administered by the same agency). For this reason, the 1,465 responding health managers represented 1,902 programs, or 68 percent of the 2,778 eligible HS/EHS programs.

These response rates—83 percent of invited directors responding for 84 percent of HS/EHS programs and 73 percent of invited health managers responding for 69 percent of HS/EHS

[1] In a few cases, more than one director made a referral to the same health manager. This occurred, for example, when the same agency had both an HS program and an EHS program, each administered by a different director sharing a health manager.

[2] Again, as detailed in Appendix B, this corresponds to AAPOR response rate 4 (AAPOR, 2015).

programs—compare favorably with other recent Head Start surveys. For example, the 2008 SHAPES surveyed all 1,810 Head Start program directors (excluding those in U.S. territories) and obtained an 87 percent response rate during a three-month field period (Whitaker et al., 2009). The 2012 Pennsylvania Head Start Staff Wellness Survey obtained participation from 73 percent of Head Start programs in the state, and 65 percent of staff in the participating programs responded to the online survey, which was administered over four months (Whitaker et al., 2013).

Weights for Survey Nonresponse

Although the goal was to obtain information from all directors and health managers, it was anticipated that there would be some degree of nonresponse and that analytic weights would be needed to account for any selectivity in which directors and health managers responded to the survey. With key characteristics of all HS/EHS programs known a priori through information available in the PIR, nonresponse weights were constructed based on a subset of those program characteristics. In particular, logistic regression models were estimated to predict the propensity of an HS/EHS program director or a Head Start health manager participating in the survey, and the inverse of the propensity was used as nonresponse weights. Extremely large weights were trimmed to avoid outliers and influential observations. The weights took into account the two-stage process of a Director Survey response, followed by a Health Manager Survey response. Weights were also constructed to allow analysis of the Health Manager survey with health managers as the unit of analysis and with the HS/EHS program as the unit of analysis. Additional detail on the constructions of the weights and their performance is provided in Appendix B.

Analytic Approach for Survey Data

The analytic approach to analyzing the survey data is consistent with the descriptive nature of the study. Beginning in Chapter Three, we present tabulations from the survey, displaying results in aggregate for HS/EHS programs and combined and separately for HS programs and EHS programs. For question items that were in the core Health Manger Survey, we also present results separately for Region XI AIAN programs and Region XII MSHS programs.[10] All results are weighted using two approaches:

- Weighting with the health manager as the unit of analysis. As noted, a single health manager may have been responding for more than one HS program or EHS program. Chapter Three focuses on a number of characteristics of health managers, so it is more natural to consider the health manager as the unit of analysis. This is equivalent to

[10] For questions in the supplemental portion of the online Health Manager Survey, such disaggregation is not valid given the smaller number of respondents in Region XI and Region XII programs in each of the four supplements (where the number of survey respondents are one-fourth as large as the entire pool of respondents). See Appendix B for the respondent counts in total and by subgroup.

analyzing the health manager workforce as the population of interest, rather than the population of HS/EHS programs. Thus, for that chapter, we weight the survey data to be representative of the Head Start health manager population.

- Weighting with the program as the unit of analysis. Starting with Chapter Four, we discuss a number of findings with respect to the Head Start health services area; for these indicators, the HS/EHS program—grantee or delegate agency—is the relevant unit of analysis. For Chapters Four to Fifteen, we weight the survey results to be representative of HS/EHS programs.

It is important to keep in mind that when the health manager is the unit of analysis, the same health manager may be serving both an HS program and an EHS program. Thus, the group of health manager respondents tabulated for HS programs overlaps to some extent with the group of health manager respondents tabulated for EHS programs. This same overlap occurs when the program (grantee or delegate agency) is the unit of analysis, as a health manager responsible for both one or more HS programs and one or more EHS programs completed one survey, but we use their responses to tabulate the results for both the HS program(s) and EHS program(s) the health managers are responsible for.

Subgroup Analyses Based on Health Manager and Program Characteristics

In addition to examining survey responses separately for HS programs and EHS programs, as well as for Region XI AIAN programs and Region XII MSHS programs, we also explored patterns using three other stratifying variables: health manager health-related education background, program size, and program rural-urban status. These analyses were intended to be exploratory, rather than explanatory, and could be conducted only for the questions in the Director Survey and core Health Manager Survey (see Appendix H for further details). For all subgroup analyses, it is important to keep in mind that any differences we observe may reflect underlying variation in how health manager or program characteristics are related to the population of children and families served, in the internal and external resources available to the HS/EHS program, and in the background and competencies of the health manager and other health services area staff. Because we conducted a descriptive study, we are interested in documenting the patterns but are not able to explain the reasons for any differences we observe.

Health Manager Health-Related Education Background

Given that HS/EHS programs have discretion in choosing the education and training background of the health managers they employ, there is interest in understanding whether there are differences in how the health services area is organized and functions based on the health manager's background (information collected as part of the online Health Manager Survey). In particular, we used information on the health manager's self-reported highest degree attained and the education field for each degree, as well as having health-related licenses, certificates, or

credentials to classify programs into one of three categories: no health-related education background (i.e., no degree in a health-related field and no health-related licenses, certificates, or credentials); no higher than an associate degree in a health-related field or one or more health-related licenses, certificates, or credentials; or a bachelor's degree or higher in a health-related field or a bachelor's degree in some other field combined with one or more health-related licenses, certificates, or credentials. Programs with more than one health manager respondent were assigned to the highest education category across the responding health managers. Using this categorization, the majority of programs represented by the respondents fall into the group with bachelor's degrees (56 percent), followed by the group with associate degrees (25 percent) and the group with no health-related education (12 percent). (This measure is missing 7 percent of programs.)

Program Size

Program size potentially affects the resources and capacity available to the health manager. Management challenges may rise as the scale of the program increases. Based on the measure of funded enrollment available in the PIR, HS/EHS grantee or delegate agencies were stratified by using the same division described earlier: small (up to 150 slots), medium (151 to 349 slots), and large (350 slots or more). This divides the 1,902 programs represented by the survey respondents into three roughly equal-sized groups.

Program Rural-Urban Status

The context within which HS/EHS programs operate (e.g., the availability of health care providers and other community partners) potentially affects how health managers and other staff structure Head Start health services and activities, such as which providers or other organizations they partner with. As discussed further below and in Appendix F, each center operated by HS/EHS grantees and delegate agencies was assigned the Census Bureau rural-urban status based on the center's census tract.[11] After aggregating across centers to the program level (grantee or delegate agency), each HS/EHS program was coded as having centers mostly in rural areas (0 to 20 percent of centers in a Census-designated urban area or urban cluster), in mixed areas (21 to 80 percent of centers in an urban area or urban cluster), or mostly in urban areas (81 to 100 percent of centers in an urban area or urban cluster). The majority of the 1,902 programs represented by the Health Manager Survey are in the mostly urban group (54 percent), followed by the mixed group (35 percent) and the mostly rural group (10 percent).

[11] Note that the address (or census tract) for the grantee or delegate agency may differ from the location of the center(s) where HS/EHS children and families are served.

Descriptive Methods

Given that we primarily present either univariate tabulations or bivariate tabulations based on program type and the other characteristics noted above, we have elected not to require a minimum number of programs for reporting purposes. For the purpose of descriptive univariate analyses on the full set of respondents, small cell sizes pose little problem—it would be nearly impossible to identify which programs reported a given response option. The ability to report detailed results allows for the greatest information to be gleaned from the data for considering future program support or training and technical assistance. Although for some questions the number of response options is quite large, these lists were reviewed and edited by Head Start health managers and other experts during the instrument development. Thus, the response options reflect the range that was important to capture.

For categorical variables, results are presented as percentage distributions. In some tables where there is no natural ordering of response categories and where response categories are not repeated across tables, we reordered the response list in the online survey so that we display the response categories in order from the most to least prevalent. (The original order for response categories can be seen in the survey instrument included in Appendix D.) For continuous variables, we present means or medians, as well as distributions using categorical divisions. Percentage distributions and means are calculated excluding respondents with missing data (i.e., the cases are excluded from the denominator), although we report the percentage of cases with missing information for reference (as table row entries in italics). In some cases, respondents indicated that a question item was not applicable, and those cases are excluded from the calculations of means, percentages, and percentage distributions. Respondents were allowed to say "don't know" for some questions. When that response was an option, we note in the tables and the text if we treat it as a separate response category or exclude those cases from calculations of summary statistics.

Finally, because of the descriptive nature of the study, we do not seek to test hypotheses about differences in survey responses by program type, by region, or by other health manager or program characteristics. Nevertheless, the narrative points to where there are differences for HS versus EHS programs that, after taking into account the margin of error for any given summary measure, would likely be statistically significant. Differences across other subgroups are also noted using the same approach. For readers interested in the confidence intervals for survey percentages, Appendix B provides lookup tables with approximate standard errors based on the survey respondents for which results are tabulated. For small subgroups—such as the Region XI AIAN or Region XII MSHS programs, the programs with health managers with no health-related education, or the group of mostly rural programs—the size of the standard errors are large enough that small differences in survey responses across subgroups will not be statistically significant.

Semistructured Interview Methods and Sample

The purpose of the semistructured interviews was to explore, in more depth, the issues raised in the web-based survey to provide more insight into specific topics. For this component, we now describe the content of the interview protocols, the selection of interview respondents, the conducting of the interviews, and the final interview sample and the characteristics of the respondents. Additional detail on the approach to the interviews and the sample of respondents is found in Appendix C.

Interview Protocols

We interviewed health managers following one interview protocol. To ensure that we had enough input on how health issues were addressed in Head Start classrooms and home settings with children and families, a second protocol was used to interview staff in three other positions: teachers, family service workers, and home visitors. Table 2.3 summarizes the topics covered in each protocol (which are included in Appendix E). Each protocol covered the following general topics:

- implementing health activities
  the role of the HSAC
- partnerships with community providers and other stakeholders
- training and support needs for the health services area.

Within these content areas, we probed specifically about facilitators and barriers to implementation, as well as factors that contributed to use and long-term uptake of programs or procedures within Head Start. Where appropriate, we queried about supports or resource that program staff would need to improve their ability to address health needs of children and families, as well as to forge strong community partnerships.

The health manager interview lasted about 45 minutes and, compared with the protocol for other staff, devoted more time to discussing how health was approached in Head Start, as well as what factors informed broader health strategic planning. We were particularly interested in understanding how health managers approach a health plan for Head Start and how they capture child and family needs, target resources, and monitor and evaluate health-related activities. Other topics included meeting the needs of the medically fragile or children living with a chronic condition population and home visiting.

Table 2.3. Content for Interview Protocols

Topic	Protocol	
	Health Manager	Teacher, Family Service Worker, Home Visitor
Planning health activities	✓	
Implementing health activities	✓	✓
HSAC	✓	✓
Serving the medically fragile/chronic-condition population	✓	
Home visiting	✓	
Partnerships with community providers and other stakeholders	✓	✓
Monitoring and evaluation	✓	
Training/support for health staff and health activities	✓	✓
Meeting the health needs of students and families		✓

The second protocol, which lasted between 30 and 45 minutes, was used with teachers, family service workers, and home visitors and emphasized classroom and home based issues and explored opportunities for support and training. Since this was our first contact with teachers, family service workers, and home visitors, we also used the interviews to capture additional, close-ended items on the health topics in which the respondent had been trained, and how long he or she had worked with Head Start. These items help to provide context regarding comfort and familiarity with the health services area.

Respondent Selection

As noted earlier, to ensure that a range of perspectives was represented, we pursued purposive sampling of Head Start health managers from among the population of health managers who responded to the Head Start Health Manager Survey. Likewise, we constructed a purposive sample of HS/EHS programs represented in the respondents to the health manager interviews for selecting the programs where we interviewed Head Start teachers, family service workers, and home visitors.

The general approach for the semistructured interviews was to sample within HS/EHS program subgroups, where we defined the subgroups based on the following characteristics, available in the PIR, listed in order of priority:

- Head Start program model (i.e., center-based HS program or EHS program and home-based HS program or EHS program)
- Head Start region (including Region XI AIAN programs and Region XII MSHS programs).

All health managers who filled out the online survey were classified according to program characteristics and randomly sampled within those strata. To ensure that all health managers had a similar chance of being selected for participation, we selected half of the sample after the online survey had been in the field for 45 days. The other half, as well as replacement selections for those health managers who did not respond, were randomly selected 90 days after that. This

helped to ensure that we were not speaking only to early survey responders. In addition, we randomly selected from the pool of Region XI health managers later in the field period, once the IRB approval process was completed.

At the end of the health manager interview, health managers were asked to nominate up to two teachers, two family service workers, and two home visitors within their programs to be invited to participate in an interview. Health managers were asked to suggest individuals who they felt could comment on the health services area. We reached out to one randomly selected teacher, home visitor, and family service worker within the program for potential inclusion in this study. If any of them refused, the other individual in the same staff category nominated by the health manager was contacted.

The number of targeted interviews—40 completed interviews with health managers and 60 completed interviews with teachers, family service workers, or home visitors—was determined to be sufficient for theme saturation and convergence according to the standard qualitative analysis protocols (Strauss and Corbin, 1990; Bernard, 2000).

Conducting the Interviews

The semistructured interviews were conducted via phone. Three trained interviewers from RAND (one of whom is fluent in Spanish) conducted the interviews with the sample of Head Start health managers selected for interview and the sample of Head Start teachers, family service workers, and home visitors selected for interview (see Appendix C for information about interviewer training). Those selected for the interviews received an email invitation to participate in the study. A letter of support for the study from the director of the Office of Head Start accompanied the email. The email explained that an interviewer would call the respondent to set up a time for an interview, answer any questions, and determine whether the respondent would prefer to conduct the interview in Spanish. Once the interview time had been established, the interviewer placed a return call to conduct the interview at the specified time.

Interviews with health managers began in May 2013 and continued through October 2013. Interviews with other staff, nominated by health managers, lagged by one month (i.e., from July to November 2013). Interviewers recorded notes on a laptop computer (after receiving consent from the respondent) using a template that followed the interview protocol. A second team member reviewed notes for clarity; this ensured that notes were ready for coding.

Final Interview Sample

Table 2.4 shows the composition of the final interview sample in total and separately by role, where family service workers and home visitors are tallied together. In total, we conducted 38 health manager interviews and 52 interviews with other program staff. Interviewees were distributed across all program types and Head Start regions. One of the health manager interviews was conducted in Spanish. For 21 programs, interviews were conducted with the health manager, a teacher, and at least one other staff member. The health manager and at least

one other staff member were interviewed for another 11 programs.[12] The overall response rate for HS/EHS health manager interviews was 59 percent, while the response rate for other staff was 43 percent.[13]

Table 2.4. Number of Interview Respondents: By Role

Group	Total	Health Manager	Teacher	Family Service Worker/ Home Visitor
All respondents	90	38	20	32
Respondents by program type				
EHS program(s) only	16	8	3	5
HS program(s) only	25	8	9	8
Both HS program(s) and EHS program(s)	49	22	8	19
Respondents by region				
Region I	4	2	1	1
Region II	4	2	1	1
Region III	7	2	2	3
Region IV	9	6	1	2
Region V	11	5	3	3
Region VI	9	3	4	2
Region VII	6	2	2	2
Region VIII	6	2	0	4
Region IX	11	5	1	5
Region X	7	3	2	2
Region XI (AIAN)	6	2	1	3
Region XII (MSHS)	10	4	2	4

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's interview data.
NOTE: Results are unweighted.

Table 2.5 shows key characteristics for the health manager interview respondents and other staff respondents. Characteristics for the former are based on the online survey responses and therefore cover additional demographic characteristics, such as age, ethnicity, and race—characteristics that we did not collect for the teachers, family service workers, and home visitors we interviewed. Appendix C shows that, for the most part, the characteristics of the health managers interviewed closely resemble the makeup of the overall HS/EHS health manager workforce, with the exception that our interviewees were somewhat more likely to be older and more experienced.

[12] Although we asked health managers to nominate at least one staff in each of three categories (teacher, family service worker, and home visitor), they did not always nominate staff in each category. In addition, we were not always able to contact or gain consent to interview staff in each category where a nomination was provided. Thus, in our completed interviews, we do not necessarily have every health manager paired with staff from the same program in each category.

[13] These response rates correspond to the AAPOR response rate 3 (AAPOR, 2015). For additional detail, see Appendix C.

Table 2.5. Characteristics of Health Manager and Other Staff Interview Respondents

	Health Manager Interview Respondents		Other Staff Interview Respondents	
Measure	**Number**	**Percent**	**Number**	**Percent**
Sex				
Female	37	97.4	51	98.1
Male	1	2.6	1	1.9
Missing	0	0.0	0	0.0
Age				
Less than 25	0	0.0	–	–
25 to 34	7	18.4	–	–
35 to 44	7	18.4	–	–
45 to 54	16	42.1	–	–
55 to 64	5	13.2	–	–
65 or older	2	5.3	–	–
Missing	1	2.6	–	–
Hispanic, Latino/a, or Spanish origin				
No	32	84.2	–	–
Yes	5	13.2	–	–
Missing	1	2.6	–	–
Race (more than one may apply)				
White	31	81.6	–	–
Black or African American	5	13.2	–	–
American Indian or Alaska Native	3	7.9	–	–
Asian or South Asian	1	2.6	–	–
Missing	1	2.6	–	–
Highest education level				
Up to high school diploma/GED	0	0.0	2	3.8
Vocational/technical diploma	3	7.9	0	0.0
Some college, no degree	1	2.6	7	13.5
Associate degree	8	21.1	13	25.0
Bachelor's degree	12	31.6	22	42.3
Graduate/professional school, no degree	2	5.3	2	3.8
Master's degree	10	26.3	5	9.6
Other postgraduate degree	0	0.0	1	1.9
Missing	2	5.3	0	0.0
Years of experience in Head Start				
Fewer than 2 years	0	0.0	7	13.5
3 to 5 years	4	11.1	12	23.1
6 to 10 years	0	0.0	16	30.8
11 to 25 years	25	66.7	17	32.7
26 or more years	4	11.1	0	0.0
Missing	4	11.1	0	0.0
Number of interview respondents	38		52	

SOURCE: Authors' analysis of Head Start Health Manager Descriptive Study's Health Manager Survey and interview data.
NOTES: Results are unweighted and based on the survey responses for the 38 health managers who completed the semistructured interviews. The demographic information for the other staff interview respondents was collected during the interview. – = not available.

Analytic Approach for Interview Data

Drawing on standard practices for analyzing qualitative data (Bernard, 2000), including grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990), the analysis plan for the

semistructured interviews with HS/EHS health managers and with HS/EHS teachers, family service workers, and home visitors included (1) identifying themes, (2) building and applying a codebook, (3) describing themes, and (4) identifying patterns. In addition, the online Health Manager Survey asked one open-ended question at the conclusion—specifically, whether there was anything that the health manager would like to share, either positive or negative, about the health services area. Because these responses did not lend themselves to a quantitative analysis (e.g., categorization), we treated the responses like qualitative data and coded them using the same approach.

Identifying Themes

To identify themes (the abstract constructs that researchers may identify before, during, and after data collection), a variety of techniques, including those from the analytic tradition of grounded theory, were used to look for examples that suggest processes, actions, assumptions, and consequences. Text management software (ATLAS/ti) was used to review texts and mark instances where each theme occurred.

Building and Applying a Codebook

To increase intercoder reliability and the validity of the findings, a codebook was developed using standard procedures.[14] Qualitative codebooks, similar to quantitative codebooks, list each theme (rather than each variable), accompanied by a detailed description, inclusion and exclusion criteria, and exemplars. Once the codebook was complete, the study team met to familiarize itself with a set of standardized procedures for marking chunks of text that pertained to each theme. To practice the procedures, we selected a random sample of transcript sections and coded each independently. On completion, the coding was reviewed as a group. Disagreement among coders suggested where the codebook might have been ambiguous and confusing. Ambiguities were fixed, and additional exemplars were included in the codebook. Upon completion of the training period, two coders analyzed each interview. The first coder took the first pass at marking the text for themes. The second coder reexamined the text to ensure that no themes had been missed. In an exploratory analysis such as this, we are more concerned with finding all examples of a theme and less concerned with calculating a measure of intercoder agreement. Using two coders helped us accomplish this goal.

[14] Two interviewers worked to develop a coding scheme and codebook based on the objectives of the interviews and types of information elicited during the interviews. Domains reflected higher-order topics, and nested within each domain were a set of codes and subcodes that enabled us to capture the relevant details of comments. For example, one domain was organizational partnerships. Within that domain were codes related to partnerships for health services, partnerships for other services (e.g., social), medical home partnerships, gaps in partnerships, and facilitators/barriers to partnerships. Within facilitators/barriers to partnerships were subdomains, including trust, prior work experience, HSAC relationship, and shared mission or accountability.

Describing Themes

Once coding was complete, we used ATLAS/ti to retrieve all instances of each theme. We reviewed these instances and described the theme by presenting segments of text—paraphrases of cases and verbatim quotes from informants—as typical and atypical examples of concepts. We also examined the distribution of the theme across all groups.

Identifying Patterns

We explored two types of patterns when appropriate: (1) "cross-group" themes that cut across all respondents and (2) "within-group" thematic similarities and differences that appear within respondent subgroups (e.g., HS programs versus EHS programs). We examined to what degree themes were central or peripheral to group members and how the themes might be distributed across various group characteristics. Our analysis suggested that there was little variation across Head Start regions. Differences that were identified could be attributed more to the location of the program (e.g., urban, rural) and availability of community resources. As a result, we do not present qualitative findings separately for regions, including Region XI AIAN and Region XII MSHS programs. Finally, we identified how themes from the qualitative interviews expanded or aligned with a quantitative data point or contradicted a survey finding.

Community Context for HS/EHS Programs Based on Geocoded Data

HS/EHS programs do not exist in isolation. They are often located in underserved areas, but with this comes important contextual factors that may shape the health priorities, approaches, and challenges of the health services area within Head Start. To gain a better understanding of the community context in which HS/EHS programs reside, we geocoded all 2,778 HS/EHS programs eligible for the online survey (see Table 2.2) and examined them in relation to a number of demographic, health, and health-related community characteristics. One set of characteristics, derived from such sources as the American Community Survey (ACS) and other publicly available databases, captures community characteristics at the county level. Several other measures are based on databases of facilities or providers that are geocoded to a specific address. These data are used to generate measures of resource availability within a given distance of the HS/EHS programs in our frame (specifically within 5, 10, 20, and 30 miles). Appendix F provides more information about the specific indicators and data sources that we rely on and the methods for aggregating the geocoded data.

As discussed in Appendix F, we matched the geocoded data first to the locations of the HS/EHS centers operated by each grantee or delegate agency, based on a list of centers and theirs latitude and longitudes provided by OHS. We then aggregated to the program level, so that the geographic characteristics associated with each program are simply the average of the characteristics for each center. If all centers are in the same county, then the county-level measures will be uniform across a program's centers. But for larger programs or those in Region

XII MSHS, it is more likely that centers will cross county boundaries. In such cases, the program-level geocoded indicators will be an average of the characteristics across one or more counties, where each center is weighted equally.

In the remainder of this section, we first examine the differences in county-level characteristics for those counties that do and do not have HS/EHS programs. This is useful for understanding the geographic reach of Head Start, as well as any differences in those counties where HS/EHS programs are located from those where they are not. We then turn to our primary interest: the geocoded characteristics of the HS/EHS programs in our study frame from the 2012–2013 program year.

Characterizing Counties with HS/EHS Programs

There are 3,221 counties in the United States, and 3,007 (93 percent) had at least one HS program center or EHS program center within their borders during the 2012–2013 program year. Table 2.6 summarizes the distribution of counties and programs by Head Start region. The percentage of counties in each Head Start region that contain HS/EHS programs varies from a low of 74 percent (Region VIII) to a high of 99 percent (Regions I, II, IV, and V).

Table 2.6. Number of Counties and Counties with HS/EHS Programs, by Head Start Region

Region	States/Territories in Region	Number of Counties	Number (Percentage) of Counties with HS or EHS	Number of HS/EHS Programs
I	CT, MA, ME, NH, RI, VT	67	66 (99%)	138
II	NJ, NY, PR, VI[a]	161	160 (99%)	325
III	DE, DC, MD, PA, VA, WV	284	277 (98%)	245
IV	AL, FL, GA, KY, MS, NC, SC, TN	736	725 (99%)	412
V	IL, IN, MI, MN, OH, MI	524	518 (99%)	467
VI	AR, LA, NM, OK, TX	503	465 (92%)	282
VII	IA, KS, MO, NE	412	361 (88%)	145
VIII	CO, MT, ND, SD, UT, WY	291	216 (74%)	132
IX	AZ, CA, HI, NV[b]	95	86 (91%)	259
X	AK, ID, OR, WA	148	133 (90%)	108
XI	Varies	–[c]	–[c]	198
XII	Varies	–[c]	–[c]	67
All	–	3,221	3,007 (93%)	2,778

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Head Start PIR data.
NOTES: – = not applicable.
[a] Region II also includes Puerto Rico and Virgin Islands.
[b] Region IX also includes the following territories: American Samoa, Northern Mariana, Micronesia, Guam, Marshall Islands, and Palau.
[c] Region XI (AIAN) and Region XI (MSHS) are based on special populations, rather than geographic boundaries. The counties with these programs have at least one other HS program or EHS program in Region I to Region X, so they do not contribute to the total number of counties shown in the final row of the table.

Table 2.7 compares the characteristics of counties with and without HS/EHS programs, as well as to the average county characteristics for the country as a whole. Overall, counties in which HS/EHS programs are located are somewhat different from those counties without HS/EHS programs. Those counties with HS/EHS programs have a higher share of African Americans and a lower share of whites, but a similar share of Latinos and non-English speakers. In counties with HS/EHS programs, median household income is somewhat lower, and the poverty rate is higher by 4 to 8 percentage points. Metrics related to health insurance coverage and child and adult health are similar, for the most part, with a few exceptions, such as the higher share of adults in poor or fair health among counties with HS/EHS programs. In terms of infrastructure and other environmental measures, counties with HS/EHS programs are more likely to have at least one urban area, with such associated features as a higher share of fast food restaurants, fewer parks per person, and higher crime rates. Counties with HS/EHS programs appear to have more health care resources overall relative to counties without HS/EHS programs, which would be expected given that the former are more urban on average.

Characterizing HS/EHS Programs

The geocoded data are particularly relevant for understanding the context within which HS/EHS programs operate and the potential implications for the health services area. Thus, we now treat the HS/EHS program, rather than the county, as the unit of analysis. As noted above, we first matched the centers operated by each HS/EHS program to county characteristics and then averaged across all centers within each program to obtain the average characteristics at the program level. Table 2.8 is based on the same characteristics reported in Table 2.7, but now for the 2,778 HS/EHS programs in our frame. Results are also shown separately for HS programs and EHS programs. Region XI AIAN programs and Region XII MSHS programs (Head Start and Early Head Start) are shown in the final two columns of the table.

Overall, the county-level indicators in Table 2.8 show that HS/EHS programs are in communities that have a larger share of minorities than counties on average (see Table 2.7): 12 percent African American and 16 percent Latino versus 9 percent and 11 percent for all counties, respectively. The average county poverty rate for children under age five across HS/EHS programs stands at 27 percent, about the same as the average across all counties. The average across many of the other indicators for HS/EHS programs are similar to the average across all counties, in part because HS/EHS programs are distributed across almost all counties (see Table 2.7). Most notably, almost half of all HS/EHS programs (46 percent) are in counties with medically underserved areas, and a similar share are in counties with shortages of health professionals specific to primary care (50 percent), mental health (53 percent), and dental health (44 percent).

Table 2.7. Characteristics of Counties With and Without HS Programs or EHS Programs

Measure	All Counties	Counties with HS/EHS Programs	Counties Without HS/EHS Programs
Demographics			
Ages 0 to 5 (%)	6.2	6.2	5.6
Race (% distribution)			
White alone	83.6	83.1	91.2
Black or African American alone	8.9	9.3	2.8
American Indian/Alaska Native alone	1.8	1.8	1.6
Asian alone	1.1	1.2	0.7
Native Hawaiian/Other Pacific Islander alone	0.1	0.1	0.1
Some other race alone or two or more races	4.4	4.5	3.5
Ethnicity (% distribution)			
Hispanic	10.5	10.5	9.7
Not Hispanic	89.5	89.5	90.3
Language spoken at home (% distribution)			
English only	83.3	83.1	85.4
Other language and speaks English very well	5.5	5.5	5.9
Other language and speaks English not very well	5.0	5.2	3.1
Family households headed by single parent (%)	33.7	34.3	24.3
Economic status			
Median household income ($)	44,973	44,720	48,527
Poverty rate (%)	16.5	16.8	12.4
Poverty rate of children under 18 (%)	23.2	23.7	17.3
Poverty rate of children under 5 (%)	27.4	28.0	19.7
Children under 6 without health insurance (%)	7.2	7.1	9.0
Child health indicators			
Low birth weights (%)	8.3	8.3	8.2
Obesity rate for low-income preschool children (%)	14.0	14.0	12.9
Teen birth rate (per 1,000 births)	45.8	46.1	39.1
Adult health indicators			
Adults in poor/fair health (%)	16.6	16.9	11.4
Adult days per month of poor physical health (*N*)	3.7	3.8	2.8
Adult days per month of poor mental health (*N*)	3.4	3.5	2.5
Adult obesity rate (%)	30.3	30.5	28.2
Adults with no leisure-time physical activity (%)	27.9	27.9	27.0
Adult smoking rate (%)	20.5	20.8	14.5
Adults without social/emotional support (%)	19.3	19.4	17.1
County infrastructure and health-related environment			
County has an urban area (%)	78.2	82.1	24.8
Limited access to healthy foods (%)	8.4	7.7	17.7
Fast food restaurants (% of all restaurants)	45.5	45.8	39.6
Recreational facilities (per 100,000 persons)	7.5	7.6	6.0
Parks (per 100,000 persons)	22.0	21.8	25.3
Average daily pollution (micrograms/cubic meter)	11.1	11.2	9.7
Water violations rate (%)	9.6	9.3	13.6
Violent crime rate (per 100,000 persons)	270.9	277.8	165.7
County health care resources			
Has a medically underserved area (%)	64.2	63.2	77.1
Has a primary care health professional shortage area (%)	63.6	62.3	80.8
Has a mental health professional shortage area (%)	75.2	74.2	88.8
Has a dental health professional shortage area (%)	55.1	54.9	57.5
Number of counties	3,321	3,007	214

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's geocoded data.
NOTE: Results are unweighted.

Table 2.8. County-Level Characteristics for HS/EHS Programs: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Demographics					
Ages 0 to 5 (%)	6.4	6.4	6.4	6.8	7.0
Race (% distribution)					
White alone	75.9	75.9	76.0	72.3	79.8
Black or African American alone	11.5	11.6	11.3	2.1	8.2
American Indian/Alaska Native alone	2.1	2.2	2.0	16.9	0.8
Asian alone	3.3	3.2	3.5	1.6	2.3
Native Hawaiian/other Pacific Islander alone	0.1	0.1	0.1	0.2	0.1
Some other race alone or two or more races	7.1	7.1	7.1	6.9	8.8
Ethnicity (% distribution)					
Hispanic	16.0	16.0	16.2	12.2	22.2
Not Hispanic	84.0	84.0	83.8	87.8	77.8
Language spoken at home (% distribution)					
English only	75.6	75.7	75.5	79.2	73.6
Other language and speaks English very well	9.7	9.7	9.6	9.9	10.8
Other language and speaks English not very well	8.4	8.3	8.5	4.1	8.6
Family households headed by single parent (%)	36.2	36.3	36.1	38.6	34.5
Economic status					
Median household income ($)	49,490	49,240	49,927	45,782	48,139
Poverty rate (%)	16.6	16.7	16.5	17.8	16.8
Poverty rate of children under 18 (%)	23.3	23.4	23.1	24.7	24.0
Poverty rate of children under 5 (%)	26.8	26.9	26.7	29.0	27.8
Children under 6 without health insurance (%)	6.4	6.4	6.3	10.6	6.6
Child health indicators					
Low birth weights (%)	8.2	8.2	8.1	6.9	7.7
Obesity rate for low-income preschool children (%)	14.3	14.3	14.3	14.9	14.9
Teen birth rate (per 1,000 births)	42.4	42.6	41.9	51.6	49.0
Adult health indicators					
Adults in poor/fair health (%)	16.5	16.7	16.2	16.1	17.9
Adult days per month of poor physical health (*N*)	3.7	3.7	3.7	3.8	3.8
Adult days per month of poor mental health (*N*)	3.5	3.5	3.5	3.4	3.5
Adult obesity rate (%)	28.5	28.5	28.4	29.6	28.9
Adults with no leisure-time physical activity (%)	25.3	25.5	25.0	24.8	24.7
Adult smoking rate (%)	19.4	19.4	19.3	22.0	18.4
Adults without social/emotional support (%)	20.9	21.0	20.8	20.4	21.2
County infrastructure and health-related environment					
In an urban area or urban cluster (%)	73.8	70.2	80.1	18.9	63.5
Limited access to healthy foods (%)	6.4	6.4	6.5	11.3	6.4
Fast food restaurants (% of all restaurants)	47.8	47.7	47.9	43.5	48.0
Recreational facilities (per 100,000 persons)	9.1	9.0	9.2	7.7	8.4
Parks (per 100,000 persons)	35.5	35.1	36.2	24.7	30.7
Average daily pollution (micrograms/cubic meter)	11.2	11.2	11.1	10.1	11.0
Water violations rate (%)	7.0	7.3	6.5	12.7	8.4
Violent crime rate (per 100,000 persons)	400.2	395.9	407.6	322.2	383.4
County health care resources					
Has a medically underserved area (%)	45.8	48.0	41.9	68.2	54.1
Has a primary care health professional shortage area (%)	49.8	50.9	48.0	76.1	67.3
Has a mental health professional shortage area (%)	52.5	53.3	51.1	81.2	63.9
Has a dental health professional shortage area (%)	43.5	43.7	43.2	65.5	52.3
Number of programs	2,778	1,767	1,011	198	67

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's geocoded data.

NOTES: Results are unweighted. For each HS or EHS program (i.e., grantee or delegate agency), county or census tract characteristics were first matched based to the program's centers and then averaged across all centers in the program to obtain the average characteristics for the program. A total of 17 programs could not be matched to county-level data (11 HS programs and 6 EHS programs, including 1 each in Region XI and Region XII). Missing data rates may be higher for some measures because they are not available for all states or counties. See Table F.2 in Appendix F for the missing data rates by variable.

For the most part, there are few differences in the county characteristics for HS versus EHS programs (in part because there is considerable overlap, with the same grantees or delegate agencies administering both programs). One exception is that EHS programs are more likely to be in counties with at least one urban area (80 percent, compared with 70 percent for HS programs). This difference carries through to a higher incidence for HS programs of being in a medically underserved area compared with EHS programs.

The county characteristics of Region XI AIAN programs and Region XII MSHS programs show the expected demographic difference (e.g., a higher AIAN share for the former and a higher Latino share and non-English-speaking share for the latter). Although median income is somewhat lower in counties with Region XI programs, many of the health-related environment and infrastructure measures are quite similar to the U.S. average. Exceptions include the higher teen birth rate in counties where both Region XI and Region XII programs are located. Region XI programs are considerably less likely to be in counties with at least one urban area, and the share with limited access to healthy food is higher. There are also fewer parks and a higher incidence of water violations in counties where Region XI programs operate. Compared with the national-level indicators, Region XI programs are considerably more likely to be in counties with a medically underserved area or with a primary care, mental health, or dental health professional shortage area. The incidence of shortage areas is also above the national average for Region XII programs.

Table 2.9 provides a closer look at the distribution of community assets relative to the locations of the centers operated by HS/EHS programs (i.e., grantees and delegate agencies). These assets capture specific providers—specifically, mental health professionals who accept Medicaid for reimbursement.[15] Other measures are for specific types of facilities—namely, hospitals, Federally Qualified Health Centers (FQHCs), medical colleges, dental schools, and mental health or social health schools. For each type of provider or facility, the table records the average share of centers at the program level that have at least one such asset within a radius of five miles, ten miles, 20 miles, or 30 miles. A final column shows the average share of centers with no assets within 30 miles. Results are shown for all HS/EHS programs in panel A and separately for programs in Region XI and Region XII in panels B and C, respectively.
As seen in the first panel of Table 2.9, most programs (i.e., grantees and delegate agencies) have centers that are reasonably close to a mental or behavioral health professional who accepts Medicaid. Considering mental health professionals who serve children and accept Medicaid, for example, on average, 64 percent of the centers operated by programs have such a professional within five miles, almost 80 percent on average have one within ten miles, and 96 percent have a child mental health professional who accepts Medicaid within 30 miles. While the majority of

[15] We searched for but did not find a similar geocoded database of dentists who accept Medicaid for reimbursement. One source we did identify was problematic in that there were likely duplicate entries, and the data source did not indicate whether the dentists were currently accepting new Medicaid patients.

program centers, on average, are located within 30 miles of medical and behavioral or mental health assets, a small percentage (no more than 9 percent) do not. These HS/EHS programs have additional barriers to meeting the needs of children and families in their care, given the paucity of medical resources in their areas.

Table 2.9. Distance to Health Providers and Facilities for HS/EHS Programs: All Programs, Region XI Programs, and Region XII Programs

Provider or Facility	Percent with at Least One Provider (by distance from program)				Percentage with No Asset Within 30 Miles
	0–5 Miles	0–10 Miles	0–20 Miles	0–30 Miles	
A. All Programs in All Regions (*N* = 2,778)					
Mental health professionals accepting Medicaid					
Outpatients only	67.5	79.3	92.9	97.0	3.0
Adult outpatients only	66.2	78.5	92.5	96.8	3.2
Child outpatients only	64.4	76.6	90.9	96.3	3.7
Hospital	70.2	83.2	96.4	98.8	1.2
FQHC	58.5	69.7	84.9	93.0	7.0
Medical college	52.4	65.1	82.0	91.5	8.5
Dental school	32.2	43.7	58.1	70.3	29.7
Mental health or social health school	30.8	42.5	56.1	68.9	31.1
B. All Region XI Programs (*N* = 198)					
Mental health professionals accepting Medicaid					
Outpatients only	25.8	45.8	73.8	86.0	14.0
Adult outpatients only	25.5	45.2	73.3	86.0	14.0
Child outpatients only	23.6	44.0	72.8	85.1	14.9
Hospital	26.0	46.4	80.7	91.1	8.9
FQHC	35.2	47.6	67.5	80.7	19.3
Medical college	17.6	31.9	55.4	70.1	29.9
Dental school	4.5	10.6	24.6	34.2	65.8
Mental health or social health school	11.3	16.8	31.6	43.0	57.0
C. All Region XII Programs (*N* = 67)					
Mental health professionals accepting Medicaid					
Outpatients only	45.9	69.4	94.8	99.4	0.6
Adult outpatients only	44.6	67.8	93.5	98.4	1.6
Child outpatients only	44.9	68.2	93.4	99.3	0.7
Hospital	49.1	75.1	98.2	100.0	0.0
FQHC	59.4	77.6	91.1	96.6	3.4
Medical college	29.5	43.7	78.9	93.6	6.4
Dental school	15.1	23.1	47.9	66.6	33.4
Mental health or social health school	14.0	23.0	43.4	64.2	35.8

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's geocoded data.
NOTES: Results are unweighted. For each HS or EHS program (i.e., grantee or delegate agency), county or census tract characteristics were first matched based to the program's centers and then averaged across all centers in the program to obtain the average characteristics for the program. A total of 17 programs could not be matched to county-level data (11 HS programs and 6 EHS programs, including 1 each in Region XI and Region XII). Missing data rates may be higher for some measures because they are not available for all states or counties. See Table F.2 in Appendix F for the missing data rates by variable.

As we will discuss later, a number of health managers reported innovative partnerships with local colleges and medical schools; as a result, Table 2.9 also includes health-related colleges and universities. About 43 percent of program centers, on average, are located within ten miles of a dental or mental health school, suggesting that these may be yet-untapped resources for many programs.

The indicators for Region XI AIAN programs in panel B and Region XII MSHS programs in panel C make it clear that Region XI programs have the least access to these assets based on where centers are located, while Region XII programs have somewhat great access but still below the overall average. On average, only about one-fourth to one-third of Region XI program centers are within five miles of a mental health provider who accepts Medicaid, an FQHC, or a hospital, and a nontrivial share have no asset within 30 miles. Regional XI programs are also less likely to be within ten to 20 miles of a health-related professional school, suggesting that for most Region XI programs, leveraging these community assets to support screening or health programming may be less feasible. In the case of Region XII MSHS programs, access is similar to the national average when the radius is set to 30 miles, but the share of centers in the program with resources at shorter distances is generally below the U.S. average.

3. The Health Manager Workforce

Relatively little information is available about the individuals who serve as health managers for HS/EHS programs. Information about the health manager workforce is not routinely collected through the PIR, and we do not have much historical data to draw on. The 1993–1995 Descriptive Study of Head Start Health Services (Keane et al., 1996) did not collect basic demographic information on the 42 health managers who were interviewed, although information on education background was covered. At that time, almost one-third of health managers had nursing training (but no degree), and another one-third had a bachelor's degree or higher. Gaining a better understanding of the education and experience of the health manager workforce has important implications for training and technical assistance and may provide insight for how to better support health managers.

Chapter Three Methods

- The health manager is the unit of analysis.
- All results are weighted to be representative of health managers.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (modules 1 and 7) are reported for health managers in all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.
- Insights from the interviews with health managers and other staff and open-ended survey responses are integrated where relevant.

Our analysis of the health manager workforce reported in this chapter focuses primarily on results from the Health Manager Survey (modules 1 and 7) (see the text box). The qualitative health manager interviews did explore in depth topics related to the health managers' backgrounds, although we report on a few issues that arose in the open-ended survey responses or the semistructured interviews. For the quantitative analyses, we examine the characteristics of the health manager workforce, viewing the 1,465 health manager respondents to the online survey as our unit of analysis. Thus, survey results in this chapter are weighted to be representative of the population of health managers rather than all HS/EHS programs. The two will differ because some health managers serve more than one program: both an HS program and EHS program, for example. Indeed, among the 1,465 Health Manager Survey respondents, 670 serve only in one or more HS programs, 201 serve only in one or more EHS programs, and the remaining 594 serve in at least one HS program and at least one EHS program.

The tables in this chapter present results from the survey core for all health managers in HS/EHS programs in all Head Start regions in one column. The next two columns also cover all regions, but we report results separately for those health managers who serve HS programs and for those health managers in EHS programs. Because some health managers serve in both types of programs, the two groups are not mutually exclusive. In other words, the same individual may

serve as the health manager for both an HS program and an EHS program, so that single set of survey responses covering his or her combined program will be included in both columns.[16]

In the final two columns, for core survey questions, we show results separately for health managers of Region XI AIAN programs and for Region XII MSHS programs. It is important to keep in mind that the number of respondents in these two categories are smaller, so the confidence intervals around the estimates are larger (see Table B.8 in Appendix B).

Finally, for the few questions on these topics that were administered as part of the survey supplement (and are therefore available for roughly 25 percent of respondents), the tables report results for all HS/EHS programs, and for HS programs only and EHS programs only. The tables report the percentage of individuals who do not respond to a given question (recorded as missing responses). However, percentage distributions throughout the report are calculated over the cases with valid responses (i.e., those cases with missing values are not included in the percentage distributions).

We begin in the next section with key demographic characteristics of the health manager workforce and then cover their education and credentialing, employment experience, job characteristics, job satisfaction, and job challenges. For the health manager workforce as a whole, key findings that emerge from the survey results include the following:

- Demographics. The workforce of health managers is predominantly female (96 percent) and diverse in terms of race (78 percent white and 16 percent African American) and ethnicity (14 percent Latino/a). One in three health managers has had a child attend Head Start or Early Head Start.
- Education. Health managers come to the job with varied backgrounds in terms of their education and training. About two in three have bachelor's degrees or higher, with nursing, child health, and community or public health being common degree fields. Nearly all health managers (91 percent) have at least had coursework in child health, and coursework is also common in such key fields as special needs, behavioral or mental health, health education, nutrition, physical fitness, and community or public health.
- Credentialing. Just over one-half of health managers have health-related licenses, certificates, or credentials. A nursing-related credential is the most common, with 25 percent of health managers having active registered nurse (RN) licenses and 11 percent having active licensed practical nurse (LPN) licenses.
- Health-related education. After accounting for highest degree; degree fields; and health-related licenses, certificates, or credentials, we found that about 58 percent of health managers have bachelor's degrees or higher in health-related fields or in combination a health-related licenses, certificates, or credentials. Just 15 percent have no health-related education background (i.e., through postsecondary degrees or licenses, certificates, or credentials).

[16] More specifically, almost one-half (47 percent) of the health manager respondents who serve in an HS program also serve in an EHS program (594 out of 1,264 respondents). A larger share, 75 percent, of the health managers who serve in an EHS program also serve in an HS program (594 out of 795 respondents). This means that when we report results separately for health managers in the two types of programs, the results will be highly correlated because of the overlap between the two groups.

- Experience. About two-thirds of health managers have had one or more Head Start positions prior to the current roles, many directly or indirectly related to the health services area, such as a disability manager/coordinator, nutrition manager/coordinator, family service worker, or home visitor. About 12 percent have been a health manager in another program, and nearly one-half have six or more years experience as an HS/EHS health manager. Overall, health managers bring considerable experience to positions involving work with children from birth to age five, and a majority has experience working in a health care setting.
- Job characteristics. Most health managers (80 percent) have responsibility for more than one site (or center), with the typical (or median) health manager covering six sites. The median health manager devotes 40 hours per week to the job and works year-round (52 weeks). The modal salary for health managers is in the range of $30,000 to $40,000; fewer than 10 percent are paid more than $60,000 per year.
- Job satisfaction and challenges. Three out of four health managers reported being satisfied or very satisfied with their jobs, yet they also identified significant challenges. The most common challenges selected by the majority of respondents pertain to follow-up for screening or treatment on the part of parents or guardians and time constraints. Other challenges relate to other resources, such as budgets and support staff, and staff training and supervision.

These highlights pertain to the overall HS/EHS health manager workforce. Throughout the chapter, we point to relevant differences for health managers in HS programs versus EHS programs, as well as in Regions XI and XII. Notable variation for these subgroups is summarized at the end of the chapter.

Health Manager Demographic Characteristics

Key demographic characteristics for health managers are shown in Table 3.1. Overall, nearly 96 percent of health managers are women, and the modal age group is 45 to 54 (31 percent). The workforce is 86 non-Hispanic or Latino/a, with 78 percent reporting that they are white, versus 16 black or African American, 5 percent American Indian or Alaska Native, and other smaller groups making up the rest. Overall, 95 percent reported that they speak English very well, and 13 percent also reported speaking Spanish at home. Given that Head Start encourages the hiring of current or former Head Start parents, it is not surprising to see that almost one-third of health managers have had a child attend Head Start or Early Head Start.

Table 3.1. Health Managers' Characteristics: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Sex (% distribution)					
Female	95.6	95.6	94.2	94.0	89.7
Male	4.3	4.4	5.7	6.0	10.3
[Missing]	*10.0*	*9.7*	*10.2*	*14.5*	*11.1*
Age (% distribution)					
Younger than age 25	1.0	0.8	1.2	0.0	2.5
25 to 34	15.0	14.2	16.1	22.7	19.6
35 to 44	25.9	24.8	25.2	20.6	32.8
45 to 54	31.4	33.0	30.7	33.8	20.7
55 to 64	22.4	22.7	21.6	19.5	19.8
65 or older	4.4	4.4	5.2	3.4	4.5
[Missing]	*9.8*	*9.4*	*9.7*	*14.5*	*11.1*
Hispanic, Latino/a, or Spanish origin (%)					
No	85.7	85.4	85.8	87.2	75.0
Yes					
Yes, Mexican, Mexican American, Chicano/a	5.4	5.2	5.2	4.8	22.4
Yes, Puerto Rican	3.9	3.9	3.7	1.8	0.0
Yes, Cuban	0.1	0.1	0.1	0.0	0.0
Yes, another Hispanic, Latino/a, or Spanish origin	5.6	5.9	6.0	6.1	2.5
[Missing]	*10.3*	*9.8*	*10.3*	*17.0*	*13.1*
Race (%)					
White	78.2	78.9	79.7	44.7	92.3
Black or African American	16.0	15.3	15.8	4.9	5.1
American Indian or Alaska Native	5.4	5.5	4.7	60.7	3.4
Asian or South Asian	2.8	2.6	2.1	3.6	2.5
Other	0.8	0.9	0.5	0.0	0.0
[Missing]	*11.4*	*10.9*	*11.2*	*16.6*	*17.3*
English proficiency (% distribution)					
Speak English very well	94.9	94.8	95.0	95.8	92.7
Speak English well	3.9	3.9	3.7	4.2	7.3
Speak English not well	0.8	0.8	1.1	0.0	0.0
Speak English not at all	0.4	0.6	0.1	0.0	0.0
[Missing]	*9.5*	*9.1*	*9.7*	*14.5*	*11.1*
Speaks a language other than English at home (% distribution)					
No	82.0	83.1	81.0	87.1	54.1
Yes					
Yes, Spanish alone or with another (non-English) language	13.1	12.6	14.1	2.9	41.1
Yes, Asian language	0.7	0.3	0.9	0.0	0.0
Yes, other language	4.2	4.1	4.0	9.8	4.8
[Missing]	*9.8*	*9.6*	*10.0*	*14.5*	*11.1*
Has or had a child who attended HS/EHS (% distribution)					
Yes	30.0	30.6	25.4	59.1	29.2
No	70.0	69.4	74.6	40.9	70.8
[Missing]	*9.6*	*9.2*	*10.0*	*14.5*	*11.1*
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentage of missing cases is shown for each measure for reference.

These patterns are generally similar for health managers in HS programs and EHS programs. Region XI AIAN programs have a larger share of individuals who identify as American Indian Alaska Native (61 percent). Those serving tribal programs are also more likely to have had a child in Head Start (nearly 60 percent compared with 30 percent on average). MSHS programs in Region XII also show some differences, with a higher share of men (10 percent) and a shift toward a somewhat younger age distribution (modal age of 35 to 44). Latinos/as make up a higher percentage of health managers in Region XII programs (25 percent versus 15 percent for the national average); consequently, a higher proportion speaks Spanish at home (41 percent versus 13 percent overall). At the same time, the percentage of health managers who reported speaking English very well is similar for HS and EHS and for Regions XI and XII.

Health Manager Education and Credentialing

Health managers were asked to report the highest education level they had attained; those results are shown in Table 3.2. Overall, the modal outcome is a bachelor's degree, reported by 36 percent of respondents. The next-highest level is 21 percent with master's degrees, followed by 19 percent with associate degrees. Across all HS/EHS health managers, 66 percent have at least a bachelor's degree; 23 percent have at least a master's degree. Relatively few (15 percent) are in the lowest education categories, with less than an associate degree. These patterns are similar for HS programs and EHS programs. Health managers in Region XI AIAN programs have a higher share with bachelor's degrees (42 percent versus 36 percent for all health managers), but they also have a lower share with master's degrees or higher (9 percent, compared with 23 percent for all health managers). Relatively more Region XII MSHS health managers have master's degrees or higher (32 percent, compared with 23 percent for all health managers).

The coursework subjects and degree fields for health managers are reported in Table 3.3. Overall, a majority of health managers have at least taken courses in such key fields as child health, special needs, behavioral or mental health, health education, nutrition, physical fitness, and public or community health. The most common fields for a bachelor's degree are nursing (18 percent), child health (16 percent), and public or community health (15 percent). Among Region XI AIAN health managers, any training through coursework or a degree is less common for nursing, special needs, health education, and public or community health. Health managers in Region XII MSHS programs are somewhat more likely to have at least coursework in medicine and a bachelor's degree in public health.

Table 3.2. Health Managers' Highest Educational Attainment: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Highest education level (% distribution)					
Up to high school diploma/GED	1.8	2.0	0.9	6.4	0.0
Vocational/technical diploma	6.6	6.8	7.5	6.0	6.3
Some college, no degree	6.4	6.9	3.2	11.2	4.9
Associate degree	19.2	20.2	17.3	22.7	12.5
Bachelor's degree	36.2	35.6	36.9	42.9	37.3
Graduate/professional school, no degree	7.2	6.9	8.3	1.8	7.1
Master's degree	20.9	19.9	23.7	8.9	29.6
Other postgraduate degree	1.8	1.8	2.2	0.0	2.2
[Missing]	*9.2*	*8.7*	*9.6*	*14.5*	*11.1*
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases is shown for each measure for reference.

Table 3.3. Health Managers' Coursework and Degrees by Field: By Program Type

Field of Study	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Child health (% distribution)					
No courses in field	8.8	9.1	7.9	8.6	5.3
Some courses in field	59.9	59.9	59.7	53.0	59.2
Associate degree in field	15.1	15.3	15.2	20.7	19.0
Bachelor's degree or higher in field	16.2	15.7	17.2	17.7	16.6
[Missing]	*11.3*	*10.9*	*11.2*	*16.0*	*11.1*
Special needs (% distribution)					
No courses in field	23.5	24.6	20.0	36.7	20.9
Some courses in field	60.8	60.5	63.3	50.0	65.4
Associate degree in field	6.1	5.7	6.9	1.8	6.3
Bachelor's degree or higher in field	9.5	9.1	9.8	11.5	7.4
[Missing]	*12.7*	*12.3*	*12.5*	*17.4*	*13.3*
Medicine (% distribution)					
No courses in field	53.4	52.9	53.3	57.3	41.9
Some courses in field	32.7	33.4	32.2	31.6	49.1
Associate degree in field	9.4	9.4	10.0	11.1	6.5
Bachelor's degree or higher in field	4.4	4.0	4.5	0.0	2.5
[Missing]	*14.1*	*13.5*	*14.0*	*17.1*	*15.3*
Nursing (% distribution)					
No courses in field	44.4	44.7	42.3	58.0	38.5
Some courses in field	13.6	13.9	12.9	19.0	32.2
Associate degree in field	24.0	25.0	26.1	17.4	16.8
Bachelor's degree or higher in field	17.8	16.4	18.7	5.7	12.3
[Missing]	*12.0*	*11.6*	*11.9*	*16.0*	*13.3*
Behavioral/mental health (% distribution)					
No courses in field	34.9	35.5	33.6	34.4	41.8
Some courses in field	51.0	50.9	50.6	51.4	53.3
Associate degree in field	4.4	4.1	5.2	4.7	0.0
Bachelor's degree or higher in field	9.8	9.4	10.5	9.4	4.9
[Missing]	*13.3*	*12.6*	*13.1*	*15.6*	*13.5*

Table 3.3. Health Managers' Coursework and Degrees by Field: By Program Type, *Continued*

Field of Study	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Social work (% distribution)					
No courses in field	47.5	47.8	45.8	46.5	43.0
Some courses in field	39.1	39.6	40.1	46.9	38.8
Associate degree in field	4.0	3.9	5.1	1.8	4.8
Bachelor's degree or higher in field	9.3	8.7	9.0	4.8	13.3
[Missing]	*13.3*	*12.7*	*13.3*	*17.0*	*11.1*
Health education (% distribution)					
No courses in field	15.9	16.3	14.3	24.4	12.8
Some courses in field	59.0	59.4	57.8	47.4	55.2
Associate degree in field	11.8	12.7	10.7	17.5	6.3
Bachelor's degree or higher in field	13.1	11.6	17.4	10.7	25.6
[Missing]	*12.2*	*11.8*	*12.4*	*16.0*	*13.3*
Nutrition (% distribution)					
No courses in field	18.4	18.9	18.6	20.8	18.0
Some courses in field	66.5	66.2	64.8	63.6	68.4
Associate degree in field	7.8	7.6	7.2	11.9	6.2
Bachelor's degree or higher in field	7.2	7.3	9.4	3.7	7.3
[Missing]	*12.6*	*12.2*	*12.7*	*16.0*	*11.1*
Physical fitness (% distribution)					
No courses in field	37.1	36.8	36.4	38.7	34.4
Some courses in field	55.2	55.6	54.0	55.1	58.0
Associate degree in field	4.1	4.1	4.9	1.8	0.0
Bachelor's degree or higher in field	3.5	3.5	4.8	4.4	7.5
[Missing]	*13.8*	*13.1*	*13.9*	*18.5*	*13.3*
Public/community health (% distribution)					
No courses in field	32.1	32.7	29.2	47.2	28.4
Some courses in field	47.4	48.1	45.2	43.7	37.0
Associate degree in field	5.9	5.4	6.9	0.0	6.3
Bachelor's degree or higher in field	14.8	13.8	18.7	9.2	28.3
Missing	*13.3*	*12.6*	*13.4*	*17.1*	*13.3*
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases is shown for each measure for reference.

Health managers were also asked to report whether they had various health-related licenses, certificates, or credentials; overall, this applied to about one in two health managers, as seen in Table 3.4. The table also shows the incidence of specific health-related licenses, certificates, or credentials and whether they are current active. Among the ten credentials listed, the most common an RN (48 percent with an active license among those with any kind of credential) or an LPN (20 percent with an active license). This means that among all health managers, about 25 percent have an active RN license (48 percent of 54 percent with any credential), and about 11

percent have an active LPN license. None of the other categories (MD, nurse practitioner, school nurse, social worker, and so on) was applicable to more than 7 percent of health managers who reported having licenses, certificates, or credentials. There is little difference in these indicators for health managers in HS programs versus EHS programs. Health managers in Region XI AIAN programs are less likely to have said that they have health-related licenses, certificates, or credentials at all. Among those with any credential, Region XI health managers have a lower rate of being an RN (34 percent versus 48 percent for all HS/EHS programs). Among Region XII MSHS health managers with any credential, a licensed vocational nurse credential is more common (13 percent), compared with health managers nationally (5 percent).

Table 3.4. Health Managers' Health-Related Licenses, Certificates, or Credentials: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Has health-related license, certificate, or credential (% distribution)					
No	46.0	46.2	45.1	64.4	50.4
Yes	54.0	53.7	54.9	35.6	49.6
[Missing]	*9.4*	*9.1*	*9.6*	*14.5*	*13.3*
Among those with licenses, certificates, or credentials, type they have (%)					
Physician (MD) or osteopath (DO)					
Currently have	0.3	0.3	0.3	0.0	5.0
Had one but not currently active	1.3	1.4	1.0	5.0	0.0
Registered nurse (RN)					
Currently have	48.4	46.1	49.5	33.6	31.4
Had one but not currently active	1.6	1.8	1.5	5.0	9.7
Licensed practical nurse (LPN)					
Currently have	19.9	21.3	22.8	20.4	9.9
Had one but not currently active	5.1	5.3	5.0	0.0	16.2
Licensed vocational nurse					
Currently have	4.6	4.6	4.7	9.8	12.7
Had one but not currently active	1.5	1.7	0.8	0.0	5.0
Nurse practitioner					
Currently have	1.2	1.0	1.3	0.0	5.6
Had one but not currently active	1.2	1.3	0.8	5.0	0.0
School nurse					
Currently have	6.8	7.1	4.7	3.5	4.9
Had one but not currently active	1.4	1.5	1.5	5.0	5.0
Social worker or counselor					
Currently have	1.9	1.9	1.8	0.0	4.7
Had one but not currently active	2.1	2.3	1.8	5.0	0.0
Psychologist or psychiatrist					
Currently have	0.4	0.5	0.8	0.0	4.7
Had one but not currently active	1.0	1.1	0.5	5.0	0.0
Dentist or dental hygienist					
Currently have	0.7	0.7	0.9	0.0	0.0
Had one but not currently active	1.4	1.6	0.7	5.0	0.0

Table 3.4. Health Managers' Health-Related Licenses, Certificates, or Credentials: By Program Type, *Continued*

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Nutritionist					
Currently have	3.0	3.5	4.1	8.5	5.0
Had one but not currently active	1.3	1.6	0.5	9.9	0.0
Other					
Currently have	23.8	23.9	22.4	26.5	45.2
Had one but not currently active	5.6	5.1	5.1	14.5	4.8
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentage of missing cases is shown for each measure for reference.

Table 3.5 provides a summary measure of the health-related education backgrounds of HS/EHS health managers, combining the information on the highest degree attained (Table 3.2), the degree field (Table 3.3), and having health-related licenses, certificates, or credentials (Table 3.4).[17] Health managers were assigned to one of three categories hierarchically:

- Health-related bachelor's degree or credentials: those with bachelor's degrees or higher in health-related fields (i.e., those fields listed in Table 3.3—namely, child health, special needs, medicine, nursing, behavioral or mental health, social work, health education, nutrition, physical fitness, or public or community health) or bachelor's degrees or higher in some other field along with health-related licenses, certificates, or credentials
- Health-related associate degree or credentials: those who do not meet the criteria for the first group but have no higher than associate degrees in health-related fields or degrees in some other field (or no degree) but health-related licenses, certificates, or credentials
- No health-related education background: those who do not meet the criteria for either the first or second group, which means that they have no postsecondary degrees in health-related fields and no health-related licenses, certificates, or credentials.

[17] As noted in Chapter Two, we use the measure in Table 3.5 as a stratifying variable for analyses in subsequent chapters (see Appendix H). In Table 3.5, we tabulate the measure of health manager health-related background with the health manager as the unit of analysis. In subsequent chapters where the program is the unit of analysis, each program is assigned to one of the three health manager education categories shown in Table 3.5, based on the highest education category across the responding health managers.

Table 3.5. Health Managers' Health-Related Education Background: By Program Type

Measure	All Regions, Total	All Regions, HS/EHS Only	All Regions, Early HS/EHS Only	Region XI, Total	Region XII, Total
Health-related education background (% distribution)					
No health-related education background	14.7	15.3	13.1	25.7	7.4
Health-related associate degree or credentials	27.4	28.8	24.8	29.6	21.2
Health-related bachelor's degree or credentials	57.9	56.0	62.1	44.6	71.4
[Missing]	*8.2*	*7.8*	*8.9*	*15.1*	*12.5*
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of HS/EHS Health Manager Descriptive Study and Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The reported measure is based on responses to highest education attainment (Table 3.2); degree fields (Table 3.3); and health-related licenses, certificates, or credentials (Table 3.4).

The distribution of health managers across these three groups (listed in reverse order) is shown in Table 3.5. For all health managers, 15 percent are classified as having no health-related education background, 27 percent have health-related associate degrees, and the remaining 58 percent have health-related bachelor's degrees or higher. Health managers in EHS programs are somewhat more likely to be in the highest education category (62 percent versus 56 percent for HS/EHS programs combined). In the case of Region XI AIAN health managers, about one in four has no health-related education background. About 71 percent of health managers in Region XII MSHS programs have health-related bachelor's degrees or higher.

The results in Table 3.5 are not intended to assess whether or not programs have health managers in place who meet requirements in the HS/EHS performance standards for "staff or consultants with training and experience in public health, nursing, health education, maternal and child health, or health administration" (Office of Head Start, 2014, 1304.52(d)(2); see Appendix A). As discussed in the next chapter, programs rely on an array of paid staff and consultants to support the health services area, so that other staff or consultants may provide complementary expertise to that of the health manager.

Health Manager Experience

Health managers were asked to report their prior experience with specific HS/EHS positions, with 15 job categories listed. Table 3.6 shows that about two in three health managers have held prior HS/EHS positions (34 percent have not held prior positions). This rate is somewhat higher for Region XI and Region XII health managers (75 and 71 percent, respectively). On average, health managers selected about two categories of prior positions (with a range from one to 11 positions selected), and the specific positions are quite varied. Most common are other positions

that directly or indirectly involve the health services area. For example, the highest share is having served as a family service worker or home visitor (19 percent) or a teacher (18 percent). Somewhat lower rates apply to being a program director or associate director (11 percent), nutrition manager/coordinator (11 percent), and disability manager/coordinator (10 percent). About 12 percent reported having been a health manager at another program. These patterns are very similar for health managers in HS programs and EHS programs. For Region XI AIAN health managers, there is a higher incidence of experience with being a teacher (24 percent), teacher's aide (19 percent), and a family service worker or home visitor (24 percent). Region XII MSHS health managers reported a higher incidence of having been a health manager at another program (21 percent). Overall, health managers in these two regions are somewhat more likely to have had any prior HS/EHS experience.

A supplemental survey question asked about years of experience in specific settings pertaining to early childhood education or health care. Table 3.7 reports these results, first for all HS/EHS health managers in panel A and then for health managers in HS programs and EHS programs in panels B and C, respectively. Although the number of respondents is small, we also report results for the Region XI AIAN health managers regarding the specific question about experience with Region XI programs, in panel D, and the same for Region XII MSHS health managers for the question specific to experience with MSHS programs, in panel E.

Overall, among all health managers (panel A of Table 3.7), 76 percent reported six or more years of experience working with children ages zero to five in an early childhood education, setting and 18 percent reported 25 or more years of experience in such settings. Years of experience working more specifically in an HS program or an EHS program are somewhat lower, but still 62 percent indicated six or more years experience with Head Start. Experience as a health manager in an HS/EHS program is somewhat less common, yet 46 percent reported six or more years in that specific position. More than half of health managers also reported having some experience working in a health care setting. These broad patterns are very similar for health managers specific to HS programs and EHS programs (panels B and C of Table 3.7).

It is far less common for health managers as a whole (panel A) to have experience with MSHS programs (about 9 percent with any experience) or with AIAN programs (about 12 percent with any experience). However, when we look at health managers in Region XI AIAN programs (panel D), 71 percent reported six or more years experience in such programs. Likewise, among health managers in Region XII MSHS programs (panel E), the share with six or more years of experience with MSHS programs reaches 53 percent. In general, health managers tend to have more experience in the settings they serve.

Table 3.6. Health Managers' Prior HS/EHS Positions Held: By Program Type

HS/EHS Position	All Regions, Total	All Regions, HS/EHS Only	All Regions, Early HS/EHS Only	Region XI, Total	Region XII, Total
No previous positions held (%)	34.4	34.2	35.0	25.4	28.7
Prior positions held					
Average number reported (*N*)	1.8	1.8	1.8	2.1	1.8
Percentage for each position (%)					
Health manager/coordinator at another HS/EHS program	11.9	11.4	13.0	9.5	21.0
Teacher	17.6	17.5	16.8	23.5	12.3
Teacher's aide/instructional aide	9.2	9.7	6.6	19.3	5.0
Family service worker/home visitor	18.9	18.9	16.2	23.5	16.8
Parent-involvement manager/coordinator or family service manager/coordinator	8.0	7.6	8.3	11.9	7.5
Outreach staff, recruiter, or enrollment manager/coordinator	4.9	4.4	4.8	6.4	2.5
Health aide	8.0	8.4	6.6	8.4	7.3
Counselor	1.9	1.9	1.8	0.0	7.4
Disability manager/coordinator	10.1	10.1	9.8	10.8	14.5
Behavioral health/mental health manager/coordinator	7.4	7.3	7.6	7.8	2.4
Nutrition manager/coordinator	10.9	11.2	11.2	10.1	12.1
Culinary or food services staff	2.1	2.1	1.2	3.5	0.0
Receptionist or office staff	5.3	5.4	5.2	11.2	2.5
Bus driver or related transportation	3.4	3.5	2.1	8.2	2.4
Director, associate director, or other program manager	11.3	11.3	11.5	8.3	2.4
Other	19.0	18.7	22.0	22.6	34.7
[Missing (%)]	*10.0*	*9.7*	*10.1*	*14.5*	*13.3*
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentage of missing cases is shown for each measure for reference.

Table 3.7. Health Managers' Years of Prior Experience in Specific Settings: By Program Type

Setting	Years of Experience (percentage distribution)					
	None	Less Than 2 Years	3 to 5 Years	6 to 10 Years	11 to 24 Years	25 or More Years
A. All HS/EHS Health Managers						
Working with children ages 0 to 5 in a child care or education setting	2.8	8.3	13.2	18.4	39.5	17.8
Working in any HS/EHS program	4.7	17.2	15.8	18.3	35.5	8.3
Working in any HS/EHS AIAN program	88.4	4.1	1.3	3.0	2.5	0.7
Working in any HS/EHS MSHS program	90.7	4.3	1.7	1.5	1.9	0.0
Working as a health manager in an HS/EHS program	3.0	27.5	23.3	17.5	23.5	5.3
Working in a health care setting	44.4	11.6	10.9	14.7	12.3	6.2
B. Health Managers in HS Programs						
Working with children ages 0 to 5 in a child care or education setting	3.2	8.3	12.3	18.9	39.8	17.3
Working in any HS/EHS program	5.1	15.4	16.0	18.8	35.3	9.3
Working in any HS/EHS AIAN program	87.9	4.2	1.2	2.9	3.0	0.8
Working in any HS/EHS MSHS program	89.8	4.5	2.0	1.6	2.1	0.0
Working as a health manager in an HS/EHS program	2.8	26.6	22.7	17.9	24.0	6.0
Working in a health care setting	44.5	12.1	9.9	14.4	13.3	5.8
C. Health Managers in EHS Programs						
Working with children ages 0 to 5 in a child care or education setting	2.3	7.2	16.0	17.7	37.3	19.7
Working in any HS/EHS program	3.0	18.4	19.9	17.9	33.7	7.0
Working in any HS/EHS AIAN program	88.4	5.4	2.0	2.2	0.6	1.4
Working in any HS/EHS MSHS program	87.6	6.6	2.2	2.3	1.2	0.0
Working as a health manager in an HS/EHS program	4.1	27.3	25.8	14.1	22.6	6.2
Working in a health care setting	40.6	13.1	12.4	14.6	12.7	6.6
D. Health Managers in Region XI Programs						
Working in an HS/EHS AIAN program	0.0	15.9	12.9	33.8	28.6	8.8
E. Health Managers in Region XII Programs						
Working in an HS/EHS MSHS program	9.5	8.2	29.2	14.2	38.8	0.0

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 376 health manager respondents in supplement B (323 in HS programs, 204 in EHS programs, 23 in Region XI programs, and 16 in Region XII programs). Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases ranges from 11 to 14 percent in panels A to C and equals 17 percent in panel D and 19 percent in panel E.

Health Manager Job Characteristics

A number of survey questions pertained to the characteristics of the health manager positions, such as the number of sites managed, hours and weeks worked, and salary. Table 3.8 shows that most health managers (more than 80 percent) are responsible for more than one site. On average, health managers cover 11 sites, although the median or typical number of sites is 6. About one in five health managers has responsibility for 16 or more sites.[18] Notably, among Region XI AIAN programs, health managers are far more likely to manage just one site (51 percent versus 18 percent for HS/EHS programs overall), with an average of under four sites, compared with 11 sites overall. In contrast, Region XII MSHS health managers are responsible for an average of 14 sites, with 34 percent having oversight of 16 or more sites.

Table 3.8 also shows that most health managers are in positions that require a full-time, year-round schedule, with an average of 38 hours per week and 49 weeks per year, including paid vacation time (medians of 40 hours per week and 52 weeks per year). This pattern holds for health managers in HS programs and EHS programs, as well as those in Region XI and Region XII programs.

Health managers were asked to report their annual salaries by selecting a range among those listed in Table 3.9.[19] The tabulations indicate that the modal health manager has a salary of $30,000 to $40,000 (a range that applies to 34 percent of health managers). About one-half of health managers are paid up to $40,000 per year. Fewer than 10 percent are paid more than $60,000 per year. The distribution of salaries is very similar for HS programs and EHS programs. Health managers in Region XI AIAN programs reported lower salaries, which may reflect, in part, the fact that AIAN programs tend to be in more-rural communities where cost of living may be lower. By contrast, health managers in Region XII MSHS programs reported higher salaries (see Table 3.8).

[18] The number of sites is highly skewed because of the number of sites managed by health managers in large HS/EHS grantees. For example, ten health manager respondents reported managing 85 or more sites.

[19] Table 3.9 does not display the percentage selecting one additional salary interval offered in the survey at the lower end (below $10,000 was combined with $10,000 to $20,000). We also combined responses for $70,000 to $80,000, $80,000 to $90,000, and more than $90,001 because there were too few cases in the three separate ranges.

Table 3.8. Health Manager Sites, Weekly Hours, and Annual Weeks: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Sites health manager is responsible for					
Mean	10.7	11.4	12.2	3.7	14.4
Median	6.0	7.0	7.0	1.0	6.0
Percentage distribution					
1	17.5	14.2	15.4	50.6	15.5
2	7.9	6.6	8.3	15.0	2.2
3 to 5	20.9	20.7	18.3	16.7	28.1
6 to 10	22.5	24.4	21.1	9.1	10.7
11 to 15	12.4	13.8	13.5	7.6	9.2
16 or more	18.8	20.5	23.3	1.0	34.2
[Missing]	*1.3*	*1.3*	*1.3*	*0.0*	*2.1*
Hours health manager worked per week					
Mean	38.3	38.6	38.9	39.3	43.2
Median	40.0	40.0	40.0	40.0	40.0
Percent distribution					
Up to 19	3.3	3.0	2.7	0.0	0.0
20 to 34	9.2	8.9	8.6	12.5	2.0
35 to 40	74.3	75.1	72.3	75.6	62.7
41 or more	11.3	11.3	14.3	9.4	33.1
[Missing]	*1.9*	*1.7*	*2.1*	*2.5*	*2.1*
Weeks health manager worked per year					
Mean	48.6	48.3	49.9	46.9	48.4
Median	52.0	52.0	52.0	52.0	52.0
Percentage distribution					
Up to 35	4.4	4.6	3.0	9.5	9.1
36 to 40	6.6	7.3	3.0	7.6	4.4
41 to 45	9.4	10.5	5.5	6.4	2.3
46 to 50	15.6	15.8	13.9	22.3	18.5
51 or more	64.0	61.8	74.5	54.1	65.7
[Missing]	*4.0*	*3.6*	*4.1*	*1.5*	*4.3*
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases is shown for each measure for reference.

Table 3.9. Health Manager Salary: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Health manager annual salary (% distribution)					
Less than $20,000	4.5	4.4	3.0	3.6	5.3
$20,001–30,000	18.1	19.0	13.4	28.3	5.2
$30,001– 0,000	33.7	34.0	33.7	38.8	20.9
$40,001–50,000	23.3	23.5	24.7	23.1	37.6
$50,001–60,000	12.2	11.5	15.3	3.0	15.9
$60,001–70,000	4.8	4.3	5.7	3.0	5.1
$70,001 or more	3.3	3.3	4.1	0.0	9.9
[Missing]	*11.7*	*11.6*	*11.2*	*16.6*	*17.1*
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases is shown for each measure for reference.

Health Manager Job Satisfaction and Challenges

Health managers were asked to report their overall job satisfaction and, as a whole, they are a reasonably satisfied workforce. As seen in Table 3.10, 31 percent and 44 percent of health managers reported being very satisfied or satisfied with their position, respectively. Just 5 percent reported being dissatisfied, and fewer than 1 percent stated that they were not at all satisfied. This pattern is very similar across the health manager subgroups shown in Table 3.10. If anything, there is some indication that Region XII MSHS health managers are even more satisfied than their counterparts in other regions.

Table 3.10. Health Manager Job Satisfaction: By Program Type

Measure (%)	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Health manager satisfaction with position (% distribution)					
Very satisfied	30.8	31.1	32.6	29.0	25.9
Satisfied	43.9	43.3	43.4	46.1	57.1
Neutral	20.0	20.2	18.6	17.2	17.0
Dissatisfied	4.8	4.9	4.6	7.7	0.0
Not at all satisfied	0.6	0.6	0.7	0.0	0.0
[Missing]	*10.9*	*10.4*	*11.4*	*18.5*	*12.5*
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases is shown for reference.

These high levels of satisfaction do not mean, however, that health managers do not face challenges in their positions. Indeed, as seen in Table 3.11, as part of the online survey, we asked about 21 possible challenges. In the table, the response categories are grouped according to three themes and reordered within each group to list responses in order from most to least prevalent among all health managers.

Health managers selected an average of 4.3 challenges (ranging from one to 19 challenges selected). The most common challenge, as reported by 66 percent of health managers, was "parents or guardians not understanding the importance of screening/treatment/follow-up." A close second choice, made by 62 percent of health managers, was "time constraints." Another group of issues was selected by 20 to 30 percent of respondents. Some of those challenges also related to the work environment or resources, including "not enough funds for supplies and activities to support health services area" (28 percent), "lack of support staff" (23 percent), "not enough health training for HS/EHS staff" (22 percent), and "not directly responsible for supervising staff that support the health team" (21 percent). Other challenges pertain to the families and children served, including "parent or guardian resistance or reluctance to speak with staff about health issues" (29 percent) and "too little time with families or inability to maintain sustained contact" (20 percent). Other issues were far less likely to be selected. These included

such challenges as "poorly defined job responsibilities" (9 percent), "not enough support from the HSAC" (6 percent), and "too few opportunities to communicate with the HS/EHS program director" (3 percent). These patterns suggest that the major issues facing health managers concern working with parents and guardians, the resources (time, budgets, support staff) available to perform the health manager role, and the training and supervision of the staff supporting the health services area.

The most-salient issues were common across the different subgroups of health managers listed in Table 3.11. However, there are some interesting differences among the lower-ranked issues. For example, in Region XII, MSHS health managers were less likely to select several of the issues related to parents, such as the time available to work with parents or parents' reluctance to speak with staff about health issues. At the same time, other issues were somewhat more prevalent, such as "difficulty enrolling families in appropriate health insurance" (18 percent versus 9 percent for HS/EHS programs overall) and "difficulty accessing health and social service providers on behalf of families" (20 percent versus 17 percent overall). The last issue was also equally prevalent among Region XI AIAN health managers. Region XI health managers were also far less likely to mention "difficulty communicating with families due to language or cultural barriers" (3 percent versus 14 percent overall).

Additional Perspectives from Health Managers on the Health Manager Position

In the semistructured interviews and in response to the open-ended question on the survey, several health managers elaborated on characteristics of their jobs and job satisfaction. Many respondents felt that salaries for health managers are quite low and "unfair" relative to the workload and program requirements. Other health managers reported that they had not received a raise in three, five, or even ten years but noted that their responsibilities continue to increase. Still others reported that their hours have been reduced (e.g., from 40 hours a week to 37.5 hours per week) as a cost-saving measure but with no lessening of responsibility, which in effect equates to a reduction in pay. Several health mangers felt that the low salaries in general contributed to turnover in their programs and also made it difficult to recruit highly qualified staff.

> *I think that the OHS needs to review how agencies are structured from the viewpoint of fair distribution of responsibilities and pay levels that equate to those responsibilities.* —Health manager
>
> *I would like to see the salary become comparable to the nurses in the area as well as take into account the years of nursing.* —Health manager
>
> *It bothers our staff that Early Head Start salaries may range higher with lower case loads. For example, in our Early Head Start program, [managers have] an average caseload of 100. Then the managers working with Head Start have caseloads of over 600 students with about 20 to 25 employees to monitor and train, and they have received, with federal cuts, about a 15 to 20 percent pay cut. It is disheartening, and we will start having high-quality staff leaving.* —Health manager

Table 3.11. Health Manager Job Challenges: By Program Type

Measure	All Regions Total	All Regions Head Start Only	All Regions Early Head Start Only	Region XI Total	Region XII Total
Conditions that make health manager job harder					
Average number reported (*N*)	4.3	4.3	4.4	4.2	4.1
Percentage for each condition (%)					
Related to job or resources					
Time constraints	62.4	63.1	63.2	57.9	63.1
Not enough funds for supplies and activities to support health services area	27.7	27.8	24.0	30.4	23.2
Lack of support staff	23.2	23.0	25.8	19.4	23.1
Not enough health training for HS/EHS staff	21.6	21.6	23.2	17.1	19.0
Not directly responsible for supervising staff that support the health team	21.0	21.0	24.7	9.8	29.5
Not enough training for me (the health manager)	19.3	18.9	18.4	27.5	20.6
Not enough support from program leadership for health services area/ organizational culture does not prioritize health	13.2	13.2	14.4	9.9	14.0
Poorly defined job responsibilities	9.3	8.6	10.3	10.3	4.7
Not enough support from the HSAC	6.4	5.7	7.4	7.0	7.6
Too few opportunities to communicate with HS/EHS program director	2.8	2.8	3.6	0.0	4.7
Related to families and children served					
Parents/guardians not understanding importance of screening/ treatment/follow-up	66.1	66.7	65.9	76.2	48.3
Parent/guardian resistance or reluctance to speak with staff about health issues	29.4	30.3	26.8	38.6	10.4
Too little time with families or inability to maintain sustained contact	20.3	20.2	21.5	25.8	13.7
Difficulty accessing health and social service providers on behalf of families	17.3	17.4	18.5	20.3	20.0
Having enough resources to serve health needs of children who do not qualify for Part B and C assistance	14.6	14.3	14.0	16.3	11.4
Difficulty communicating with families due to language or cultural barriers	13.9	14.3	12.8	2.6	13.6
Lack of materials at the appropriate literacy/health literacy/reading level	11.9	11.0	13.5	16.4	11.2
Difficulties related to undocumented children and families	11.2	11.1	13.0	1.5	17.7
Difficulty enrolling families in appropriate health insurance program	9.9	10.1	10.1	8.1	18.0

Table 3.11. Health Manager Job Challenges: By Program Type, *Continued*

Measure (%)	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Related to policies					
Administrative requirements from OHS	12.5	12.4	13.5	11.4	15.8
State or local policies	4.3	4.2	4.7	0.0	2.9
[Missing]	*3.8*	*3.5*	*3.5*	*1.5*	*4.3*
Number of health manager respondents	1,465	1,264	795	76	46

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentage of missing cases is shown for reference.

Summary of Chapter Findings

Overall, the survey results indicate that the health manager workforce is diverse in demographic background, education, training, and experience. Many health managers bring specific and relevant training in health areas to their positions, and the HS/EHS workforce overall has experience in other Head Start roles, in working with young children, and in other areas of the health care sector.

The demands of the health manager position can be seen in the extent to which most are responsible for multiple sites and most work full-time and year-round. There is variation in salaries that may reflect differences in job responsibilities and cost of living, as well as the salary structure in the Head Start program. However, as several health manager respondents noted, salaries are low in some instances relative to education, training background, and job responsibilities.

For the most part, these patterns are very similar for health managers working in HS programs and those in EHS programs, which is not surprising given the overlap between the two groups.

Based on questions in the core survey, there are some differences in the health manager workforce's key indicators for Region XI AIAN programs and Region XII MSHS programs. Most notably, a majority of health managers in Region XI AIAN programs are American Indian or Alaska Native (60 percent), while one in four health managers in Region XII MSHS programs is Latino/a. Region XI AIAN health managers are less likely to have at least a bachelor's degree and have a lower rate of health-related licenses, certificates, or credentials, especially RNs. Region XII MSHS health managers, in contrast, are more likely to have health-related education backgrounds than the overall HS/EHS health manager workforce. Health managers in both regions have more experience in prior Head Start positions than the national average, and many have long tenures as health managers in their respective regions.

In terms of job characteristics, Region XI AIAN health managers typically have oversight over a smaller number of sites, while the reverse is true for Region XII MSHS health mangers.

Although hours and weeks of work are similar to the national pattern, Region XI health managers reported somewhat lower salaries, while Region XII health managers reported somewhat higher salaries. Health managers in Regions XI and XII reveal similar levels of satisfaction with their jobs, as compared with health managers in HS/EHS as a whole, and the pattern of top-ranked challenges are largely similar as well.

4. Staffing and Professional Development for the Health Services Area

As noted in Chapter One, HS/EHS programs have considerable discretion and flexibility over how they staff the health services area to accomplish their objectives. Consequently, it is important to understand how programs structure staff roles and responsibilities to meet the requirements of the health services area and to understand the range of expertise required. It is also helpful to understand the professional-development supports available to the health manager and other staff delivering or overseeing health services, because that provides a basis for ongoing skill development.

Chapter Four Methods

- HS/EHS programs (i.e., grantee and delegate agencies) are the unit of analysis
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (module 1) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.
- Insights from the interviews with health managers and other staff and open-ended survey responses are integrated where relevant.

The 1993–1995 Descriptive Study of Head Start Health Services provides some evidence regarding these issues, documenting, for example, that more than one-half of health managers reported performing multiple roles (Keane et al., 1996). In the present study, these issues were largely addressed through the Health Manager Survey (module 1), and we report on the relevant survey results in this chapter, first examining how the Head Start health services area is staffed and then turning to the health-related professional-development supports available to health managers and others. In addition, during our interviews with health managers and other program staff, we talked further about the approaches to staff training and specific training needs. Thus, we report on the results of those conversations as well.

In contrast to Chapter Three (see the text box), we now treat the HS/EHS program (grantee or delegate agency) as the unit of analysis, so all survey results are weighted to be representative of all HS/EHS programs. Because some health managers serve more than one program, the 1,465 health manager respondents are reporting for 1,902 programs. As with the prior chapter, we report results for all HS/EHS programs in all regions, separately for HS programs and EHS programs in all regions, and also separately for Region XI and Region XII programs (both Head Start and Early Head Start). We omit results for the two regional subgroups for survey questions in the supplement because of the small number of survey respondents. For core survey questions,

we also examine patterns for programs defined by the health manager's health-related education background, program size, and rural-urban status.

We begin with examining staffing considerations and then turn to professional development. In terms of staffing the health services area, the highlights of our analysis of survey and interview respondents for all regions and program types include the following:

- In most HS/EHS programs (70 percent), the health manager serves in at least one other role, although the health manager role is usually primary, requiring 75 percent of the time for the typical health manager with multiple roles. Most often, the second role is serving as a nutrition manager/coordinator. It is somewhat less common for the health manager role to be combined with the behavioral and mental health manager/coordinator or the disability manager/coordinator. While combining responsibilities may be a necessity of the Head Start staffing model and resource constraints, it can be a source of frustration for health managers who would like more time to devote to the health services area.
- Health managers are often responsible for administrative tasks, goal and objective monitoring, health services coordinating, and prevention and health-promotion activities, but responsibilities are not only vested with the health manager. Other staff in administrative roles are also involved in the health services area, as are those who are directly involved with children and families (e.g., teachers, family service workers, and home visitors).
- There is no uniformity of practice in terms of the frequency of meetings between the health manager and other program staff, although communication is key for coordination.
- The range of expertise required in the health services area necessitates the use of consultants in many HS/EHS programs. Among paid consultants, the most common is a nutritionist or a dietician. Common volunteer consultants or partners, used by a majority of programs, include dentists, dental hygienists, and public health experts.
- Because programs serve diverse populations, linguistic and cultural competence on the part of HS/EHS staff are vital. About one-half of HS/EHS programs reported being able to communicate in all relevant primary languages spoken by the children and families they serve. The vast majority (80 percent) of programs reported having the required cultural expertise vested in their staff or consultants.

Key findings with respect to professional development include the following:

- Health managers typically receive training on a wide array of topics pertaining to physical and oral health, behavioral health and developmental delay, and prevention and wellness, although training on some topics is more prevalent than for others. When training does not occur, it is most often because it is not available or not applicable. Beyond topic-based training, health managers in interviews also spoke of the need for orientation supports for those new to the health manager role.
- Although there is variation across training topics, most training occurs in the local area; online training is relatively uncommon (at most 16 percent of training on any given topic uses this mode). Common providers include local organizations and community partners, professional organizations, and HS/EHS program staff. The train-the-trainer model is also used to make training information available to more staff in a cost-effective way.

- For the most part, health managers do interact with health managers in other programs, with the modal interaction being one or two connections a year. However, health managers in 16 percent of HS/EHS programs did not have any connections with a fellow health manager in the previous year.
- Most HS/EHS programs also have health-related training available for other staff, often with emphasis on the same topics that health managers experience. In interviews, health managers reported selecting training topics for staff based on staff feedback and other priorities or needs. Staff interviewed pointed to the need to go beyond just learning about a health topic; they need to receive guidance on the implications of the trainings for their everyday work.
- Nearly all HS/EHS programs provide at least some level of support for the training of health managers and other staff. Most common is paying for registration fees and for travel costs, a benefit that usually applies to all staff. Less common is staff coverage or tuition reimbursement.

Throughout the chapter, we note where these patterns differ for HS versus EHS programs and for Region XI or Region XII programs, as well as by other health manager and program characteristics. Any such differences are summarized in the concluding section of the chapter.

Staffing the Head Start Health Services Area

The Health Manager Survey included questions about the responsibilities of the health manager and other staff in the delivery of the health services area. The role of specialists and the linguistic and cultural competencies of the staff are other topics we covered.

Health Manager Roles in HS/EHS Programs

As was the case two decades ago, Table 4.1 shows that many HS/EHS programs continue to have a health manager who serves in other roles. Overall, just under 30 percent of programs have a health manager who is exclusively dedicated to the role. Another 33 percent of health managers have one other role, while the remaining 38 percent serve in two or more other roles.[20] This general pattern is very similar for HS programs and EHS programs, but differences are more evident for the Region IX and Region XII grantees. Region XI AIAN grantees are more likely to have a health manager who serves in other roles (84 percent), while the opposite is true for Region XII MSHS grantees, where 44 percent of grantees have a health manager with no other job titles. A further comparison based on other health manager and program characteristics (see Table H.4.1 in Appendix H) shows that health managers with no health-related education background are more likely to serve in other roles (81 percent), compared with those who have health-related associate or bachelor's degrees (67 percent and 70 percent, respectively). Serving in other roles in addition to the health manager role is also more common for smaller programs than larger ones (74 percent for those in programs with fewer than 150 enrollees versus 65

[20] The online Health Manager Survey provided space to list up to three other roles.

percent in programs with 350 or more enrollees) and more common in programs in mostly rural areas than mostly urban ones (77 percent versus 68 percent).

Table 4.1. Health Manager Roles: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Health manager roles (% distribution)					
Health manager role only	29.1	27.7	31.6	15.7	43.8
Health manager role and 1 other role	32.9	33.1	32.6	23.4	33.2
Health manager role and 2+ other roles	38.0	39.2	35.8	60.9	23.0
[Missing]	*2.4*	*2.2*	*2.8*	*1.1*	*5.0*
If other roles, roles are (%)					
Teacher	0.9	0.8	1.0	1.6	0.0
Teacher's aide/instructional aide	1.7	1.7	1.7	8.4	0.0
Education manager/coordinator	4.8	4.4	5.4	8.7	0.0
Family service worker/home visitor	9.7	8.4	12.1	22.6	2.9
Outreach staff/recruiter/enrollment manager/coordinator	8.1	7.4	9.3	14.3	0.4
Counselor	1.5	1.7	1.2	3.5	0.0
Disability manager/coordinator	17.3	16.7	18.5	21.6	20.3
Parent-involvement manager/coordinator	7.1	8.3	4.8	15.3	0.4
Behavioral/mental health manager/coordinator	19.0	19.0	19.0	25.4	15.0
Nutrition manager/coordinator	54.0	53.7	54.5	45.4	60.8
Culinary or food services staff	9.2	10.0	7.7	15.8	0.0
Receptionist/office staff	5.3	5.5	5.1	16.3	0.0
Bus driver or related transportation	3.9	4.6	2.8	17.6	5.0
Director, associate director, or other program manager	11.0	12.0	9.0	15.3	10.2
Other role	40.4	39.5	42.1	33.2	41.3
[Missing]	*2.3*	*2.0*	*2.8*	*1.4*	*7.6*
If other roles, share of time for health services area					
Mean %	68.6	67.6	70.5	60.5	72.0
Median %	75.0	75.0	75.0	60.0	75.0
Percentage distribution (%)					
Up to 30 percent	14.2	14.3	14.0	21.0	0.0
31 to 50 percent	21.7	22.3	20.7	27.2	24.5
51 to 70 percent	11.7	12.1	10.9	9.0	23.5
71 to 80 percent	19.8	19.5	20.6	14.4	14.6
81 to 90 percent	15.4	15.1	15.8	9.6	17.5
91 to 99 percent	6.7	6.9	6.4	6.4	6.3
100 percent	10.3	9.7	11.5	12.4	13.5
[Missing]	*1.4*	*0.9*	*2.2*	*0.0*	*0.0*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table 4.1 also shows which other roles health managers are most likely to take on. A low percentage for any role may indicate that health managers are not likely to serve in that position

or that few programs include that position on their staffs. With that caveat in mind, the most common other role is nutrition manager/coordinator (54 percent), followed by behavioral and mental health manager/coordinator (19 percent) and disability manager/coordinator (17 percent)—all roles related to the health services area that are referenced directly or indirectly in the performance standards (see Appendix A). In contrast, it is very rare that the health manager also serves as a classroom teacher or teacher aid (combinations reported for fewer than 2 percent of programs). There are some differences across program types in terms of how the health manager role may be combined with other positions. For example, Region XI AIAN programs have a relatively higher share of health managers also serving as family service workers or home visitors (23 percent versus 10 percent, on average).

The other roles a health manager plays also vary based on the health manager's health-related background, program size, and urbanicity (see Table H.4.1 in Appendix H). For example, health managers with no health-related education background are more likely to serve in other positions that are not health related, such as outreach staff (18 percent); director, associate director, or other program manager (15 percent); family service worker (13 percent); receptionist or other office staff (13 percent); education manager/coordinator (11 percent); or parent-involvement manager/coordinator (11 percent). In turn, compared with those with a health-related background, those without a health-related background are no more or less likely to serve as the behavioral or mental health manager/coordinator (20 percent) or disability manager/coordinator (19 percent), but they are considerably less likely to serve as nutrition manager/coordinator (43 percent). Compared with health managers in larger programs, health managers in smaller programs are more likely to be in other roles as a disability manager/coordinator (20 percent), a family service worker or home visitor (19 percent), outreach staff (15 percent), or a parent-involvement manager/coordinator (12 percent). Health managers in programs in mostly rural areas versus mostly urban areas are overrepresented in other roles as behavioral or mental health managers/coordinators (29 percent), receptionists or office staff (11 percent), and bus drivers or related transportation positions (10 percent). These patterns show that there is considerable variation across HS/EHS programs in how the health manager position is configured, some of which may be related to the health manager's own background, while features of the program may also play a role.

Health managers with more than one role were asked to report the percentage of time devoted to the health manager role; responses ranged from 1 percent to 100 percent. The results are summarized in the bottom of Table 4.1. On average, when the position is shared with other job titles, 69 percent of the health manager's time is devoted to the health services area. At the median, the proportion of time for the health manager role reaches 75 percent, and 10 percent reported that all time (100 percent) was for the health services area despite having multiple roles. In Region XI AIAN programs, where health managers are more likely to combine roles, the percentage of time devoted to the health services area is lower (60 percent). For health managers serving in more than one role, the share of time allocated to the health manager role also varies

with other health manager and program characteristics (see Table H.4.1 in Appendix H). For instance, those with health-related associate or bachelor's degrees reported a higher percentage of time (70 percent) spent in the health manager role versus those with no health-related degrees (54 percent). The proportion of time spent in the health manager role is lower for health managers in smaller programs (60 percent) than large ones (74 percent). And health managers in urban programs spend more of their time in the health manager role (71 percent of time on average), compared with health managers in rural areas (61 percent on average).

HS/EHS Staff Responsibilities for Health Services Area Tasks

The health services area is associated with a multiplicity of tasks, so a supplemental question in the Health Manager Survey inquired about the person with primary responsibility for 30 distinct tasks covering the most-relevant health services area activities. Table 4.2 presents the responses, showing the percentage of programs where the health manager has primary responsibility for a given task versus another staff member, or where the task is not performed at all. What is evident from Table 4.2 is that responsibility for the health services area is not vested exclusively in the health manager. Tasks related to the administration of the health services area are more likely to fall to the health manager, such as conducting administrative responsibilities (95 percent of programs), monitoring the health services area to meet its goals and objectives (94 percent of programs), completing the PIR (81 percent), and ordering health-related supplies (80 percent). Health managers are also likely to take the lead on key tasks related to health promotion and prevention activities, such as collecting and creating resource materials (89 percent of programs), conducting teacher and staff training on health issues (87 percent of programs), planning for the health curriculum (73 percent), and providing education for parents and guardians (72 percent). Another key health manager responsibility is coordinating health-screening activities (88 percent of programs). Yet primary responsibility for many other tasks listed in Table 4.2 fall to other staff.

Table 4.2. Responsibilities for Health Services Area Tasks: All Program Types

	Person Primarily Responsible for Task (percentage distribution)			
Specific Task	**Health Manager**	**Someone Else**	**Not Done**	***[Missing]***
Daily health checks of children	12.9	83.4	3.6	*0.5*
Coordinating health-screening activities	87.9	12.1	0.0	*0.6*
Conducting health screenings/assessments	50.5	49.0	0.5	*0.6*
Coordinating immunizations	61.2	29.7	9.1	*0.8*
Providing immunizations	2.1	65.4	32.4	*0.5*
Medication management of HS/EHS children	58.1	37.5	4.4	*0.5*
Providing acute care/treatment for children, staff, and parents/guardians	25.2	55.5	19.3	*1.0*

Table 4.2. Responsibilities for Health Services Area Tasks: All Program Types, *Continued*

Specific Task	Person Primarily Responsible for Task (percentage distribution)			
	Health Manager	Someone Else	Not Done	*[Missing]*
Providing counseling/therapeutic services for children and families	11.1	78.8	10.1	*1.0*
Developing IHPs	56.5	37.5	6.1	*0.8*
Making or arranging referrals for health services	68.1	31.4	0.4	*0.7*
Follow-up on health services provided by others (e.g., case management)	72.1	27.3	0.6	*0.8*
Working with direct-service providers to establish MOUs, formal partnerships or agreements	70.1	28.2	1.8	*0.8*
Negotiating payments for services paid for by HS/EHS funds	49.4	39.5	11.1	*0.7*
Health curriculum planning	72.8	24.9	2.3	*1.1*
Collect/create health-related resource materials	89.4	10.5	0.0	*0.7*
Ordering health-related supplies (e.g., toothbrushes, first aid kits)	78.9	21.1	0.0	*0.5*
Parent or guardian health education	71.7	27.9	0.3	*0.4*
Teacher and staff training on health issues	86.8	12.5	0.7	*0.2*
Classroom safety and injury prevention	64.6	33.9	1.5	*0.8*
Determining the amount of physical activity and movement in the daily schedule	20.5	74.6	4.8	*1.0*
Monitoring the amount of time children spend being physically active	18.0	75.1	6.9	*0.8*
Menu planning	26.1	71.3	2.5	*0.5*
Food purchasing	11.4	85.4	3.2	*0.7*
Food preparation	3.7	93.1	3.2	*0.5*
Helping families access publicly funded insurance (e.g., Medicaid/SHIP, SCHIP)	33.6	65.2	1.2	*0.5*
Helping families access publicly funded nutrition services (e.g., WIC, SNAP).	30.1	68.5	1.3	*0.2*
Administrative responsibilities (e.g., reviewing reports for compliance, health record maintenance)	95.3	4.4	0.3	*0.2*
Completing the PIR	80.9	19.1	0.0	*0.2*
Monitoring of the health services area budget	48.3	51.2	0.5	*0.2*
Monitoring of the health services area to meet its stated goals and objectives	93.7	6.3	0.0	*0.7*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 373 health manager respondents for 486 programs in Supplement A. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases is shown for reference. IHP = individual health plan; MOU = memorandum of understanding; SHIP = State Health Insurance Assistance Program; SCHIP = State Child Health Insurance Program; SNAP = Supplemental Nutrition Assistance Program.

In a supplemental question, health managers were asked which staff role had primary responsibility for a health-related task for which the health manager did not have primary responsibility. Table 4.3 summarizes those responses by showing for each staff role which tasks were most likely to be selected by health manager respondents as primary health-related responsibilities for other staff. All tasks mentioned for a given staff member by 5 percent or more of programs are listed in the table. In many cases, the division of labor corresponds with

staff members' areas of expertise and their roles in the program. For example, the nutrition manager/coordinator is most likely to have primary responsibility for menu planning (46 percent of programs), followed by food purchasing (32 percent of programs) and then food preparation (20 percent). Home visitors and family service workers are most likely to have responsibility for helping families access nutrition services and public health insurance (37 percent and 34 percent, respectively), among other tasks. These same tasks also sometimes fall to the family service manager/coordinator. Teaching staff are most likely to be responsible for daily health checks of children (75 percent) and monitoring the amount of time spent in physical activity (31 percent). In some cases, primary responsibility falls to an outside health provider (most common for providing immunizations, for example) or a consultant.

Table 4.3. HS/EHS Staff with Primary Responsibility for Health Services Area Tasks: All Program Types

Staff Role and Tasks with Primary Responsibility	Percentage of Programs
Nutrition manager/coordinator	
Menu planning	46.2
Food purchasing	32.2
Food preparation	19.8
Helping families access publicly funded nutrition services	5.0
Mental health manager/coordinator	
Providing counseling/therapeutic services for children and families	20.8
Home visitors/family service workers/family advocates	
Helping families access publicly funded nutrition services	36.6
Helping families access publicly funded insurance	34.3
Making or arranging referrals for health services	11.8
Follow-up on health services provided by others	11.7
Parent or guardian health education	7.2
Conducting health screenings/assessments	6.0
Coordinating immunizations	6.2
Family service manager/coordinator	
Helping families access publicly funded insurance	14.9
Helping families access publicly funded nutrition services	11.3
Education manager/coordinator	
Determining the amount of physical activity and movement in the daily schedule	34.8
Monitoring amount of time children spend being physically active	28.6
Health curriculum planning	8.6
Classroom safety and injury prevention	6.2
Teaching staff (including teachers/teacher aide)	
Daily health checks of children	75.4
Monitoring amount of time children spend being physically active	30.6
Determining the amount of physical activity and movement in the daily schedule	23.2
Medication management of HS/EHS children	12.8
Classroom safety and injury prevention	11.0
Health curriculum planning	6.1
Providing acute care/treatment for children, staff, and parents/guardians	6.1
Program director	
Monitoring of the health services area budget	35.9
Negotiating payments for services paid for by HS/EHS funds	20.6
Work with direct service providers to establish MOUs	11.5

Table 4.3. HS/EHS Staff with Primary Responsibility for Health Services Area Tasks: All Program Types, *Continued*

Staff Role and Tasks with Primary Responsibility	Percentage of Programs
Other HS/EHS staff	
Food preparation	49.1
Food purchasing	33.8
Conducting health screenings/assessments	16.0
Ordering health related supplies	15.3
Monitoring of the health services area budget	12.0
Completing the PIR	11.2
Negotiating payments for services paid for by HS/EHS funds	10.4
Medication management of HS/EHS children	10.2
Classroom safety and injury prevention	10.0
Follow-up on health services provided by others	9.0
Making or arranging referrals for health services	8.8
Coordinating immunizations	7.9
Parent or guardian health education	7.9
Developing IHPs	7.8
Helping families access publicly funded insurance	7.8
Helping families access publicly funded nutrition services	7.0
Coordinating health-screening activities	6.1
Providing acute care/treatment for children, staff, and parents/guardians	5.6
Collect/create health-related resource materials	5.2
Menu planning	5.1
Teacher and staff training on health issues	5.0
Outside health provider (e.g., oral health, behavioral health, physical health)	
Providing immunizations	60.5
Providing acute care/treatment for children, staff, and parents/guardians	37.6
Providing counseling/therapeutic services for children and families	37.3
Conducting health screenings/assessments	16.8
Coordinating immunizations	9.9
Developing IHPs	9.7
Medication management of HS/EHS children	6.9
Other consultant	
Menu planning	14.1
Food preparation	11.6
Food purchasing	10.0
Providing counseling/therapeutic services for children and families	8.9
Developing IHPs	8.2

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 373 health manager respondents for 486 programs in Supplement A. Tasks are listed when at least 5 percent of health managers reported that it was a primary responsibility for a given staff member or other entity. No primary responsibilities met this threshold for oral health managers/coordinators, disability managers/coordinators, parent-involvement managers/coordinators, or members of the HSAC. Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases.

Given that responsibilities for the health services area are distributed across multiple staff members, one challenge is likely to be communication about activities under way, issues that need resolution, and planning. Table 4.4 shows the frequency with which meetings are held related to the health services area, according to a question in the survey supplement. Across all HS/EHS programs, most common is a monthly meeting (34 percent), although such meetings are held less frequently for a greater share of programs (about 40 percent), while a smaller share of programs meets even more often (18 percent). This pattern is quite similar for HS programs and EHS programs.

Table 4.4. Frequency of Meetings for Health Services Area: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Frequency of meetings (% distribution)			
Up to once a year	5.2	5.4	4.7
Twice a year	13.6	15.6	10.2
Every two to five months	20.8	20.4	21.6
Every month	34.3	34.5	34.0
Several times a month	8.0	7.5	8.8
Weekly	10.2	9.6	11.3
Other	7.9	7.0	9.4
[Missing]	*2.0*	*2.1*	*1.8*
Number of health manager respondents	373	331	205
Number of programs	486	300	186

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Role of Specialists in Health Services

Because of the wide range of expertise required for the tasks associated with the health services area, a supplemental question in the Health Manager Survey inquired about the use of 16 specific types of specialists. Table 4.5 reports the percentage of HS/EHS programs across all program types that rely on one or more specialists in each category and if that specialist (or those specialists) was as a member of the paid staff, volunteer staff, a paid consultant or community partner, or a volunteer consultant or community partner. Since programs may work with more than one individual in a given category of specialists, respondents could select more than one relationship category.

Table 4.5. Work with Specialists: All Program Types

Specialist	Percentage Using Specialist in Capacity (more than one may apply)				
	Paid Staff	Volunteer Staff	Paid Consultant/ Community Partner	Volunteer Consultant/ Community Partner	Do Not Work With, Not Applicable, or Don't Know
Social workers	39.1	2.5	14.7	20.2	26.1
Nurses	37.0	5.1	28.0	32.2	6.7
Physicians	1.3	6.4	22.7	47.8	22.9
Physician assistants	1.0	3.3	17.6	30.3	44.2
Psychiatrists	0.7	2.1	18.0	13.9	60.3
Psychologists	10.5	2.2	32.7	19.7	35.5
Parent-education specialists	29.2	4.4	8.8	19.2	39.1
Parent-engagement specialists	46.5	3.0	6.0	8.2	35.7
Counselors	15.0	2.2	31.8	24.5	28.9
Nutritionists and dieticians	27.7	2.8	52.0	20.9	2.1
Dentists	2.4	5.2	28.0	56.4	11.8
Dental hygienists	1.8	4.6	22.9	52.5	17.0
Early intervention staff	19.9	2.4	16.3	40.4	21.6
LEA special education staff	17.1	3.4	14.8	47.8	15.3
Health educators	19.0	7.2	11.0	50.9	17.7
Public health practitioners	2.8	4.7	17.9	52.8	21.1
Other specialist	6.3	0.0	1.0	2.9	20.5

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 373 health manager respondents for 486 programs in Supplement A. Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentage of missing cases is 3.0 percent. LEA = local education agency.

Overall, the patterns in Table 4.5 indicate that HS/EHS programs rely on an array of specialists, and the nature of the relationship—on staff or not, paid or volunteer—varies considerably as well. Among the specialists listed in Table 4.5, nutritionists or dieticians are engaged almost universally, typically as a paid consultant or community partner (52 percent) but sometimes as paid staff (28 percent) or a nonstaff volunteer (21 percent). Nurses are likewise engaged by almost all HS/EHS programs, most often as paid staff (37 percent) but also often as a consultant (paid or volunteer) or community partner (28 percent and 32 percent, respectively).[21] Dentists and dental hygienists are also common specialists, with most programs relying on a nonstaff volunteer relationship (56 percent for dentists and 52 percent for dental hygienists). Other specialists who are typically engaged as nonstaff volunteers include public health practitioners (53 percent), health educators (51 percent), physicians (48 percent), and LEA special education staff (48 percent). Beyond those already mentioned, specialists who are most likely to be included as paid staff include parent-engagement specialists (47 percent), social workers (39 percent), and parent education specialists (29 percent). Psychiatrists are the least

[21] These figures do not include the share of programs where the health manager has a nursing background.

likely to be used by HS/EHS programs among the specialists listed in Table 4.5, and when they are engaged, it is typically as a paid consultant or community partner (18 percent).

Language and Cultural Competences of HS/EHS Staff

Because of the diversity of the linguistic backgrounds of HS/EHS children and families and the need to communicate health-related information to families, health managers were asked to indicate if none, some, or all of the primary languages of the children and families served by their programs are spoken and understood by any of the programs' staff members. Table 4.6 shows that all primary languages are covered by staff in 53 percent of programs, while at least some of the primary languages are covered in the other 47 percent of programs. Notably, while this pattern is similar for HS programs, EHS programs, and Region XII MSHS programs, health managers in 86 percent of Region XI AIAN programs reported that staff spoke and understand all primary languages. When we compared the share speaking all primary languages based on health manager subgroups (see Table H.4.6 in Appendix H), we found that the percentage was highest for health managers with no health-related education background (65 percent versus 51 percent for those with health-related bachelor's degrees), for health managers in small programs (62 percent versus 46 percent for large programs), and for health managers in programs with centers concentrated in mostly rural areas (77 percent versus 48 percent for those in mostly urban areas). These differences likely reflect the less heterogeneous populations in HS/EHS programs that are smaller and that are in rural areas.

The share of programs where the health manager reported that all primary languages of children and families are spoken and understood by staff is related to the composition of the enrolled children in terms of the language spoken at home. We used the PIR to divide programs into three equal-sized groups based on the share of children speaking English as the primary language at home. In programs where the PIR shows that 95 to 100 percent of children speak English as their primary language at home, 72 percent of programs are reported by health managers to speak all primary languages. When 0 to 70 percent of children speak English as their primary language at home, 53 percent of programs are reported by health managers to speak all primary languages. For the more heterogeneous middle group, where 70 to 95 percent of the children served speak English as the primary language at home, just 36 percent of programs are reported by health managers to speak all primary languages. Thus, programs with either very few or very many dual-language learners are the most likely to cover all relevant languages.

Table 4.6. Language and Cultural Competencies of HS/EHS Staff: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Languages spoken and understood by HS/EHS staff (% distribution)					
All primary languages of children and families	53.1	52.5	54.3	85.6	53.1
Some primary languages of children and families	46.7	47.5	45.4	14.4	46.9
No primary languages of children and families	0.2	0.1	0.3	0.0	0.0
[Missing]	*2.0*	*2.0*	*1.9*	*0.0*	*0.6*
Program has teachers, staff members, or consultants who provide guidance on ethnic customs, culture, traditions, and values that may relate to the health, behavioral health, and oral health of the children and families in the program (% distribution)					
Yes	79.3	79.6	78.7	82.3	87.5
No	15.1	14.8	15.7	14.4	9.0
Don't know	5.6	5.5	5.7	3.3	3.5
[Missing]	*2.2*	*2.3*	*2.0*	*0.0*	*6.2*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Health managers were also asked to indicate whether they "have teachers, staff members, or consultants who provide guidance on ethnic customs, culture, traditions, and values that may relate to the health, behavioral health, and oral health of the children and families in program." As shown in Table 4.6, health managers for 79 percent of HS/EHS programs combined reported that they have access to such guidance, a share that was very similar for both HS programs and EHS programs. The percentage of health managers with access to such guidance was slightly higher for Region XI AIAN programs (82 percent) and for Region XII MSHS programs (88 percent). There were no important differences in health manager responses based on subgroups defined by the health manager's health-related education background, by program size, or by program urbanicity (see Table H.4.6 in Appendix H).

Additional Perspectives from Health Managers on Staffing

Given the numerous responsibilities noted by health managers and the fact that most hold more than one position within their programs, it is not surprising that many health managers reported the need for additional staff. While some programs seem well staffed, and health managers reported that they "feel lucky," others noted that they think that one health manager or nurse for a large program is insufficient. While health managers reported "doing what is needed" to meet

basic standards, there was a general sense that they could do better and that the program would be stronger if additional staff were devoted to the health services area.

> *I oversee the health, disabilities, nutrition, and mental health aspects of our program. Sometimes it is overwhelming, and I feel that I manage them all but not as well as I could if I didn't have all of the areas and could concentrate on just a couple of them.* —Health manager

> *I feel privileged to have a job where I can help children, and I work very hard to improve the quality of our services. However, I have a huge workload, and have reached the point that some very important projects don't even get started because there just aren't enough hours in the day. I've worked in Head Start for 14 years and am exhausted. The needs of children and families increase every year, but the external and internal resources stay the same while my list of responsibilities gets bigger and each project becomes more involved.* —Health manager

> *I really enjoy what I do with Head Start. I have been here almost 20 years. If feel that if I had more help in this area, I could focus more on where I need to focus. This is a tremendous load, and I cannot do this by myself. I transport all of the children to the dentist after my regular bus run. I schedule all of the dental appointments. I put the physical information in the [tracking software] program, update all the records, make sure shots are up to date. . . . I could go on and on.* —Health manager

While many of these comments pointed to the need for more nurses and staff with health backgrounds, others focused on the challenges of data entry and noted, instead, that they would appreciate having dedicated administrative support.

> *If I had someone assisting me with my duties and responsibilities, I am confident that I would accomplish, achieve, and succeed in my role as the health services manager.* —Health manager

> *I love my job. We do our best to meet all the needs of our children, but I would love to have at least one administrative staff that works with me so I could focus on the children instead of administrative responsibilities and data collection, so no one slips through the cracks.* —Health manager

Professional Development for the Head Start Health Services Area

Questions about support for professional development included in the Health Manager Survey centered on the training for the health manager themselves, although we also addressed professional development for other HS/EHS staff. In addition, our qualitative interviews touched on issues related to staff training for the health services area.

The Health-Related Training and Professional Development of Health Managers

Health managers were asked in the survey to report on training in the past three years for an array of topics pertaining to physical and oral health (13 topics), behavioral health and developmental delay (9 topics), and prevention and wellness (17 topics). Health managers could

indicate whether they had received training on the topic and, for those who had not received training, whether the training was available but they chose not to take it, or not available, or not applicable. Results are shown for all HS/EHS program types in Table 4.7.

Overall, health managers are receiving training on a wide array of topics in each of the three domains: physical and oral health, behavioral health and developmental delay, and prevention and wellness, albeit training is more likely in some areas than others, and there are some topics for which training is less likely to be available. Among the physical and oral health topics, training was most common for proper use of medical items (74 percent), tooth decay or cavities (74 percent), overweight and obesity (68 percent), infectious disease (64 percent), and asthma (63 percent). When training was not received, a majority of health managers indicated that the training on that topic was not available. This was most common for specialized topics, such as tuberculosis (TB); ear infections; anemia; and underweight, stunting, or failure to thrive, where 50 percent or more indicated that training was not available.

Among the behavioral health topics, training was most common for child abuse and neglect (92 percent), family violence (60 percent), and substance abuse (53 percent) and least common for posttraumatic stress disorder (PTSD) (25 percent) and anxiety (30 percent). Again, with the exception of child abuse and neglect, where there was almost universal participation, when training was not taken, most health managers reported that it was not available.

Finally, in the prevention and wellness category, training was almost universal for CPR and other first aid (90 percent), preventing disease spread (88 percent), universal precautions (83 percent), nutrition and healthy eating practices (83 percent), and oral hygiene (90 percent). There are just two topics on which fewer than one-half had training: prenatal and postpartum issues (36 percent) and bed bugs (41 percent). For the most part, among those who did not receive training on a prevention and wellness topic, the training was not available. Among those who did not receive training on this subset of topics, food safety and CPR and first aid were the only topics where more health managers reported that it was available than not available.

Health managers who received training on each of the topics listed in Table 4.7 were asked to report the location of the training (reported in Table 4.8) and who provided the training (reported in Table 4.9). In terms of location, the dominant place where training was received was in the local area. The topics covered locally ranged from a high of 94 percent for CPR and first aid to a low of 61 percent for overweight and obesity. The share receiving online training ranged from 1 percent (for CPR and other first aid) to 16 percent (for ear infections). The remainder received training outside the local area, a share that was as low as 4 percent (for child neglect or abuse) and as high as 33 percent (for physical activity or fitness). There is considerably more variation in the source, or provider, of the training. Depending on the topic, the modal training provider was most frequently a local organization or community partner. Otherwise, the next most common provider was either HS/EHS program staff or a trade association or other professional group. Least common was training provided by OHS.

Table 4.7. Training for Health Managers in Past Three Years: All Program Types

Training Topic	Health Manager Training Status in Past Three Years (percentage distribution)				
	Had Training	No Training, but Available	No Training, Not Available	Training Not Applicable	*[Missing]*
Physical and oral health					
Diabetes	41.9	10.2	37.9	10.0	*4.1*
Overweight and obesity	68.4	9.0	18.1	4.5	*3.6*
Underweight, stunting, failure to thrive	33.5	7.2	50.5	8.9	*4.3*
Asthma	62.9	10.3	22.9	3.9	*3.6*
Vision conditions	50.3	7.8	36.5	5.4	*3.7*
Hearing conditions	53.7	7.3	33.5	5.6	*3.6*
Ear infections	28.9	6.1	54.7	10.4	*4.3*
Lead poisoning	52.7	7.1	34.4	5.9	*4.0*
TB	24.3	6.6	57.0	12.2	*4.3*
Anemia	30.6	6.9	53.4	9.1	*4.3*
Infectious diseases	63.7	4.6	26.1	5.7	*4.1*
Proper use of medical items	74.4	5.8	14.4	5.5	*3.8*
Tooth decay or cavities	73.7	4.9	16.1	5.3	*4.6*
Behavioral health and developmental delay					
Child neglect or abuse	92.4	2.7	2.6	2.4	*3.0*
Family violence	60.4	11.2	20.5	7.9	*3.9*
Substance abuse	52.8	13.0	25.4	8.7	*3.9*
ADHD or ADD	37.1	15.9	34.6	12.4	*4.4*
PTSD	24.9	12.6	47.6	14.9	*4.5*
Depression	39.0	12.9	35.2	12.9	*4.5*
Anxiety	30.0	12.8	43.0	14.3	*4.6*
Autism spectrum disorders	45.1	19.4	25.3	10.2	*4.5*
Developmental delays	47.0	16.9	25.5	10.5	*4.4*
Prevention and wellness					
General health promotion or wellness	76.1	4.0	15.7	4.2	*4.0*
General child development	65.2	11.2	18.8	4.9	*4.1*
Oral hygiene	79.9	3.9	12.4	3.8	*3.8*
Immunizations	65.8	6.5	22.7	4.9	*3.9*
Nutrition or healthy eating practices	82.9	5.7	8.7	2.8	*3.7*
Physical activity or fitness	72.6	9.1	13.7	4.6	*3.9*
Food safety	65.9	15.2	12.3	6.6	*3.9*
Injury prevention and safety	59.4	7.6	25.7	7.4	*4.5*
CPR and other first aid	90.4	6.9	1.1	1.6	*3.6*
Preventing spread of disease	87.7	3.0	6.8	2.5	*3.9*
Head lice	54.7	6.0	32.6	6.7	*4.4*
Bed bugs	40.6	7.6	41.6	10.2	*4.3*
Environmental concerns	58.3	6.4	28.1	7.2	*4.4*
Prenatal or postpartum issues	35.7	14.5	32.3	17.5	*4.5*
Emergency preparedness	73.1	7.0	15.8	4.0	*4.0*
Universal precautions	83.3	2.7	10.0	4.0	*4.3*
Health literacy communication	57.9	5.8	28.0	8.3	*4.7*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 1,465 health manager respondents for 1,902 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference. ADD = attention deficit disorder.

Table 4.8. Training Location for Health Managers Who Had Training in Past Three Years: All Program Types

Training Topic	Training Location for Those with Training (percentage distribution)			
	Local Area	Outside of Local Area	Online	*[Missing]*
Physical and oral health				
Diabetes	69.4	21.2	9.4	*2.8*
Overweight and obesity	60.8	28.8	10.3	*2.2*
Underweight, stunting, failure to thrive	67.1	24.8	8.1	*2.5*
Asthma	67.7	20.6	11.7	*2.4*
Vision conditions	68.1	23.2	8.7	*1.9*
Hearing conditions	61.1	27.4	11.5	*1.9*
Ear infections	60.3	24.1	15.5	*3.5*
Lead poisoning	70.8	18.7	10.6	*2.8*
TB	75.3	16.2	8.5	*3.7*
Anemia	74.9	17.4	7.7	*3.3*
Infectious diseases	76.2	14.2	9.6	*1.8*
Proper use of medical items	75.9	10.4	13.7	*2.5*
Tooth decay or cavities	65.6	26.2	8.2	*2.3*
Behavioral health and developmental delay				
Child neglect or abuse	89.6	4.0	6.4	*1.7*
Family violence	85.3	10.6	4.0	*2.0*
Substance abuse	82.9	11.7	5.4	*2.4*
ADHD or ADD	68.1	24.5	7.3	*3.4*
PTSD	62.6	28.7	8.8	*3.4*
Depression	70.8	21.7	7.5	*2.1*
Anxiety	70.0	22.6	7.4	*2.7*
Autism spectrum disorders	66.6	26.6	6.8	*2.6*
Developmental delays	78.1	18.0	3.9	*3.5*
Prevention and wellness				
General health promotion or wellness	72.4	21.0	6.6	*2.2*
General child development	74.7	19.1	6.2	*2.5*
Oral hygiene	72.7	20.9	6.4	*2.4*
Immunizations	74.5	15.2	10.2	*2.2*
Nutrition or healthy eating practices	70.5	23.0	6.5	*2.0*
Physical activity or fitness	61.1	33.2	5.8	*2.2*
Food safety	78.0	13.1	9.0	*2.2*
Injury prevention and safety	78.0	14.3	7.7	*2.0*
CPR and other first aid	93.7	5.5	0.8	*1.8*
Preventing spread of disease	84.1	8.2	7.7	*2.0*
Head lice	77.4	11.9	10.7	*2.1*
Bed bugs	68.5	14.6	16.9	*2.2*
Environmental concerns	68.8	20.4	10.8	*2.2*
Prenatal or postpartum issues	64.8	24.6	10.6	*2.4*
Emergency preparedness	80.0	14.1	5.9	*1.9*
Universal precautions	88.6	5.6	5.8	*2.2*
Health literacy communication	62.2	30.4	7.4	*2.2*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 1,465 health manager respondents for 1,902 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table 4.9. Training Provider for Health Managers Who Had Training in Past Three Years: All Program Types

Training Topic	Training Provider for Those with Training (percentage distribution)				
	HS/EHS Program Staff	Local Organization or Community Provider	Trade Association or Other Professional Group	OHS	*[Missing]*
Physical and oral health					
Diabetes	8.6	53.1	35.4	3.0	*1.2*
Overweight and obesity	18.3	39.6	29.2	12.9	*2.1*
Underweight, stunting, failure to thrive	22.2	41.7	32.0	4.2	*1.0*
Asthma	9.3	54.7	30.5	5.5	*2.5*
Vision conditions	10.5	48.3	35.3	5.9	*1.8*
Hearing conditions	10.1	42.7	37.6	9.6	*1.8*
Ear infections	10.7	48.2	35.4	5.8	*1.3*
Lead poisoning	10.5	60.1	23.2	6.3	*2.1*
TB	13.8	55.2	29.2	1.8	*0.8*
Anemia	16.8	51.7	27.6	3.9	*1.2*
Infectious diseases	19.9	52.3	24.1	3.7	*1.7*
Proper use of medical items	25.3	44.3	24.0	6.5	*2.2*
Tooth decay or cavities	10.6	49.3	24.5	15.6	*2.0*
Behavioral health and developmental delay					
Child neglect or abuse	29.8	55.0	13.8	1.4	*2.5*
Family violence	20.9	60.7	16.4	2.0	*2.1*
Substance abuse	14.0	65.9	18.1	2.0	*2.0*
ADHD or ADD	12.7	50.0	34.0	3.3	*1.9*
PTSD	12.3	46.8	38.2	2.7	*1.1*
Depression	15.1	49.0	33.6	2.3	*1.4*
Anxiety	13.8	47.9	36.1	2.1	*1.4*
Autism spectrum disorders	12.1	46.7	38.5	2.8	*1.7*
Developmental delays	24.4	46.6	25.4	3.7	*1.8*
Prevention and wellness					
General health promotion or wellness	22.7	44.1	23.0	10.2	*2.3*
General child development	31.3	37.9	23.9	6.9	*2.4*
Oral hygiene	18.2	46.0	22.6	13.2	*2.6*
Immunizations	13.3	57.6	25.8	3.3	*2.1*
Nutrition or healthy eating practices	25.1	44.7	22.4	7.8	*2.5*
Physical activity or fitness	18.7	38.0	25.2	18.1	*2.3*
Food safety	24.6	47.2	26.0	2.2	*1.8*
Injury prevention and safety	25.5	48.7	21.2	4.6	*1.8*
CPR and other first aid	25.6	54.2	19.5	0.7	*2.5*
Preventing spread of disease	33.4	45.2	17.8	3.5	*2.1*
Head lice	32.2	43.7	20.5	3.6	*1.9*
Bed bugs	21.4	48.1	26.4	4.1	*1.3*
Environmental concerns	14.7	52.5	25.0	7.8	*2.1*
Prenatal or postpartum issues	20.0	39.6	31.1	9.3	*1.1*
Emergency preparedness	28.9	46.4	18.3	6.3	*2.0*
Universal precautions	40.2	41.9	15.8	2.1	*2.3*
Health literacy communication	22.4	35.2	24.5	17.9	*2.0*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 1,465 health manager respondents for 1,902 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Another potential type of professional development opportunity for health managers is interactions with their peers. Health managers were asked to report on the number of times they connected with other health managers in the past year. As seen in Table 4.10, just 16 percent of health managers reported no contact with other health managers over the prior year. Of those who had such interactions, most common was one or two such connections (39 percent), followed by three to six connections (30 percent). These percentages are very similar for HS programs and EHS programs. Region XII MSHS health managers reported somewhat fewer interactions, but Region XI AIAN health managers are even less likely to be connected, with 38 percent reporting no interactions with fellow health managers in the prior year.

Table 4.10. Health Manager Connections with Other Health Managers: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Number of times connected with other health managers in past year (% distribution)					
No connections	16.4	16.5	16.1	37.7	20.5
1 to 2 times	39.0	39.7	37.9	39.5	48.1
3 to 6 times	29.7	29.8	29.4	14.0	19.4
7 or more times	14.9	13.9	16.6	8.9	11.9
[Missing]	*3.8*	*3.9*	*3.6*	*4.4*	*3.4*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

For the measure of health manager connections with other health managers in the past year, we also examined differences across subgroups based on the health manager's health background, the program size, and the program rural-urban status (see Table H.4.10 in Appendix H). Health managers with no health-related education background were somewhat more likely to report having no connections with other health managers, compared with health managers who have a bachelor's-level health-related degree (18 percent versus 14 percent). Health managers in smaller programs were more likely to indicate that they had no connections with other health managers in the past year, compared with their peers in large programs (20 percent versus 12 percent). Likewise, health managers in programs with centers concentrated in rural areas were more likely to report no contact with other health managers, compared with their counterparts in programs with centers concentrated in urban areas (28 percent versus 15 percent).

Health-Related Training of Other HS/EHS Staff

In a supplemental question, health managers were asked to report whether their programs provided training, either on-site or off-site, in the past three years for other program staff. The list covered the same set of topics discussed in Tables 4.7 to 4.9, and, again, there is considerable variation in the incidence of training across the different topics (see Table 4.11). As with health managers, the most common training is for child abuse or neglect (86 percent), followed by several prevention and wellness topics: CPR and other first aid (85 percent), preventing infectious disease spread (78 percent), nutrition and health eating practices (76 percent), food safety (71 percent), general child development (70 percent), oral hygiene (69 percent), and general health promotion and wellness (68 percent). The proper use or administration of medication, medical equipment, or medical supports is also prevalent (73 percent). The same specialized topics that had low incidence for health managers are likewise less likely for other staff to receive (e.g., TB, ear infections, PTSD, anxiety, bed bugs, and anemia).

Table 4.11. Training Provided for Other HS/EHS Staff in Last Three Years: All Program Types

Training Topic	Percentage of Programs
Physical and oral health	
Diabetes	34.0
Overweight and obesity	59.8
Underweight or stunting or failure to thrive	30.0
Asthma or other lung disease	55.2
Vision conditions	36.6
Hearing conditions	36.8
Ear infections	20.3
Lead poisoning	43.3
TB	17.7
Anemia	27.1
Infectious diseases	59.9
Proper use or administration of medication, medical equipment, or medical supports	73.4
Tooth decay or cavities	58.7
Behavioral health and developmental delay	
Child neglect or abuse	86.4
Family violence	61.7
Substance abuse	49.8
ADHD or ADD	38.6
PTSD	21.7
Depression	33.9
Anxiety	27.7
Autism spectrum disorders	45.2
Developmental delays	59.4

Table 4.11. Training Provided for Other HS/EHS Staff in Last Three Years: All Program Types, *Continued*

Training Topic	Percentage of Programs
Prevention and wellness	
General health promotion or wellness	67.8
General child development	69.9
Oral hygiene	68.5
Immunizations	44.6
Nutrition or healthy eating practices	75.7
Physical activity or fitness	67.3
Food safety	70.5
Injury prevention and safety	59.1
CPR and other first aid	84.9
Preventing spread of infectious disease	78.0
Head lice	53.1
Bed bugs	33.2
Environmental concerns	49.4
Prenatal or postpartum issues	40.2
Emergency preparedness	67.5
Universal precautions	74.1
Health literacy or health communication	46.7

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 373 health manager respondents for 486 in Supplement A. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases is 6.0 percent.

Another supplemental question concerned training staff for emergency preparedness. Table 4.12 shows, according to health manager responses, the frequency with which emergency preparedness education sessions or training occur. Overall, health managers in 7 percent of HS/EHS programs reported that no such regular trainings occur. For the remaining 93 percent of programs, the modal frequency is once a year (60 percent). Another 12 percent receive training twice a year, while 18 percent have more-frequent trainings. The frequency distribution is very similar for HS programs and EHS programs.

Support for Training and Professional Development

Health managers were asked to report on the availability of various supports to facilitate attendance at health-related trainings external to the program. Four types of support were referenced: paying for staff registration fees, paying for travel and lodging costs, providing substitute staff to cover responsibilities while at the training, and providing tuition reimbursement for relevant college courses. Health managers were asked to indicate whether each type of accommodation was available for themselves (health managers) only, for other staff only, for all staff, or not available at all. Table 4.13 tabulates the results, first for all HS/EHS programs regardless of type in panel (a) and then separately for HS programs and EHS programs.

Table 4.12. Frequency of Staff Participation in Emergency Preparedness Education or Training: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Frequency that staff members participate in emergency preparedness education sessions or training (% distribution)			
Never, staff members do not regularly participate in such trainings	7.2	7.4	6.7
Once a year	59.6	61.9	55.4
Twice a year	11.9	11.3	13.0
Every two to five months	7.4	6.1	9.6
Every month	10.7	10.4	11.5
Other	3.2	2.9	3.8
[Missing]	*10.1*	*9.4*	*11.4*
Number of health manager respondents	376	323	204
Number of programs	483	298	185

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table 4.13. Supports to Make Training Easier for Health Managers and Other Staff: By Program Type

	Availability of Training Support (percentage distribution)					
Training Support	Available for HM Only	Available for Other Staff Only	Available for All Staff	Not Available	Don't Know	*[Missing]*
A. All Regions, Total						
Pay staff registration fees	18.3	2.2	73.9	2.5	3.0	*4.1*
Pay for travel and lodging	18.7	2.2	70.4	4.2	4.6	*4.4*
Provide staff coverage	6.6	14.1	42.5	28.9	7.9	*6.6*
Provide tuition reimbursement	6.7	9.3	40.5	26.4	17.1	*6.0*
B. All Regions, HS Programs Only						
Pay staff registration fees	19.5	2.3	71.8	2.6	3.8	*4.2*
Pay for travel and lodging	19.5	2.2	68.3	4.6	5.5	*4.5*
Provide staff coverage	7.4	14.2	41.8	27.9	8.7	*6.8*
Provide tuition reimbursement	6.7	9.3	40.4	26.1	17.5	*6.2*
C. All Regions, EHS Programs Only						
Pay staff registration fees	16.1	2.1	77.6	2.4	1.7	*3.9*
Pay for travel and lodging	17.4	2.0	74.3	3.6	2.9	*4.4*
Provide staff coverage	5.2	13.9	43.7	30.7	6.4	*6.2*
Provide tuition reimbursement	6.7	9.2	40.6	27.0	16.5	*5.6*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 1,465 health manager respondents for 1,902 programs (1,264 health manager respondents in HS programs and 795 health manager respondents in EHS programs). Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference. HM = health manager.

Across all HS/EHS programs, paying for registration fees and for travel and lodging are almost universally available and typically for all staff (70 to 74 percent of programs), but some programs make those accommodations for health managers only (18 to 19 percent). It is less common for programs to provide staff coverage or tuition reimbursement, supports not offered by 29 percent and 26 percent of programs, respectively. Again, when they are offered, programs are most likely to make the support available to all staff (41 to 43 percent of programs). Interestingly, staff coverage is the support that is most likely to be offered only for other staff (14 percent versus 2 to 9 percent for the other types of support for other staff)—presumably this is for classroom staff, for whom such coverage is essential. A comparison across panels A, B, and C shows that the overall patterns are mirrored in the separate results for HS programs and EHS programs.

Additional Perspectives from Health Managers and Staff on Staff Training

Our semistructured interviews with health managers and other program staff (teachers, home visitors, and family service workers), as well as responses to open-ended questions from the Health Manager Survey, provided an opportunity to learn more about how HS/EHS programs approach staff training for the health services area, along with specific training needs. We discuss our findings in those two areas in turn.

Approach to Training Staff

Consistent with the survey results reported earlier in this chapter (Tables 4.7 to 4.9 and Table 4.11), health managers and staff participating in semistructured interviews noted that staff are trained annually and throughout the year on a wide range of health-related issues, conditions, and, to a lesser extent, health-related curricula. Health managers noted that while some training topics are required, others are selected based on staff feedback provided to the health manager either informally (e.g., discussions about a rising concern in the classroom) or through regular staff training surveys. Training topics are also driven from the community-needs assessment and the health needs of the children entering the program.

> *For staff, we have an annual training survey that is distributed by the training coordinator in my office. We tally the feedback on their needs. What they feel is important is prioritized.* —Health manager

> *We train [staff] monthly and do our training based on the needs we see, based on [tracking system data], home visit observations, home visit journals, and parent surveys.* —Health manager

Most of the health managers reported having a more-intensive one- to two-week in-service training for staff at the beginning of the school year, with supplemental trainings throughout the year. Although the in-service training may include nonhealth topics, health and safety have a strong emphasis. Annual refreshers on mandated training topics (e.g., child abuse) were most often addressed at the start of the school year. The format and frequency of the supplemental

trainings was more varied across programs; some health managers presented a shorter weekly training on a health-related topic of interest, others conducted monthly trainings, and others held trainings on an as-needed basis. All health managers reported additional, more-intensive training with staff who would be working with a child with special health care needs. These trainings may include the proper use of medical supports, medication administration, signs and symptoms of distress, and emergency protocols. Some of these trainings are conducted by the health managers, but physicians and the child's parent or guardian may also conduct them.

> *We train each teacher individually who has a student with a health concern. That is an intense training. Then there are staff meetings where I raise a health issue and talk about seizures—for example, what they may learn, how to tell if the child is having one. This happens two to three times over the course of the school year.* —Health manager

While health managers conducted many of the trainings, there was recognition that full-day or full-week training days were perceived as long, particularly if limited to only one or two trainers. To address this, health managers reported bringing in experts from the community to provide training on a specific health topic. Health managers also noted the use of a train-the-trainer model. If a teacher or family service worker attended an external training, for example, the staff member who attended the training was asked to provide training for the rest of the staff. One external training opportunity cited frequently was the UCLA/Johnson and Johnson Health Care Institute, which provides HS/EHS agencies with tools and resources to foster parent engagement and promote health literacy. This training is provided in person for teams of HS staff.

Health managers and other health staff were also interested in free or low-cost external training opportunities that could be pieced together to meet the unique training needs of the individual staff member. While many programs reported in the survey that funds were available to support trainings (see Table 4.13), survey responses also indicated that the majority of trainings occurred in the local area (see Table 4.9). During interviews, health managers reiterated that they were not always able to take advantage of trainings offered at or through national organizations or conferences, because time and resource constraints limit the number of trainings that health managers and other staff can attend outside the local area. Online offerings, such as live or recorded webinars, were viewed as providing a flexible option for training when time was available.

> *For training, the dollars and time are not there. I have to choose what is most cost-effective. I love webinars, and I have seen more and more of those. I would rather just see things sent via the Internet or sources that you can pick and choose as opposed to something that is cookie-cutter. Everyone is different, I would like something that is helpful but not something that I have to use, that we all have to use. That is what I would be looking for.* —Health manager

> *I think webinars would be great. It's hard to leave my facility for a conference, but webinars can get done. If a webinar is held earlier in the day, I can get more involved. If it is taped, that is even better.* —Health manager

Training Needs for Health Managers

Health managers were asked about training needs as part of the semistructured interviews, and training needs were also raised during the open-ended responses to the Health Manager Survey. One topic rose to the top as particularly salient for health managers: the need for basic training on how to be a health manger.

Health managers recalled starting in their jobs with little to no training and no one available to turn to for help. Most new health managers either have (1) a health background but less experience with Early Head Start or Head Start or (2) experience with Early Head Start and Head Start but less experience with some of the health-related activities. At present, a health manager competency does not exist to guide program directors in a set of the knowledge, skills, and abilities of an effective health manager. In addition, Head Start performance standards do not specify the qualifications for the health services area content experts (e.g., the health manager), but health services be supported by staff or consultants trained or with experience in public health, nursing, health education, maternal and child health or health administration. As a result, some health managers have formal training in a health-related field, while others do not (although HS/EHS grantees and delegate agencies may have their own requirements). As a result, training is needed to fill these gaps. In addition, mentoring was mentioned as a true gap that could be filled by more deliberate connections with other health managers, particularly if more experienced health managers were paired with novice ones.

> *For me, health manager training would be very effective to go over the requirements, standards, what current Head Starts are doing, different strategies, stakeholders, and resources that are available.* —Health manager

> *Even though I have learned a great deal from hands-on experience, in my three years as health manager, I do not feel I have received enough training to be effective as a health manager.* —Health manager

> *I am very new to this position. I am learning new things every day and want to learn as much as I can. I need help figuring out what is the best way to conduct the duties that are required and how to make them better. I would have loved a basic training course on this and found information for Head Start, but it is hard to find the answers to the questions I have about it. I think all health managers should visit another site and do job shadowing with a program that is like theirs, or there should be an introduction training to all health staff.* —Health manager

Of note, subsequent to when the interviews were conducted for this study, the *Health Manager's Orientation Guide* was updated on the Early Childhood Learning and Knowledge Center website (OHS, 2015a), which could provide introductory information and training for health managers.

Training Needs for Staff

Despite annual and as-needed trainings on specific topics, some health managers reported a general concern with the lack of general health-related knowledge among staff who are expected to support health programming and activities.

> *I am the only medically trained person for our program. . . . We have eight program sites and have untrained staff making health decisions and tracking health for the children.* —Health manager

A related concern was raised by staff—a need for trainings with more specificity, actionable steps, and implementation guidance. Staff noted that a lot of trainings are available, but they focus largely on the educational piece—explaining what the condition is but stopping short of providing practical advice for how to handle this issue in the Early Head Start or Head Start setting. This makes it difficult for staff to appropriately address health issues or concerns.

> *We need things we can implement in the classroom and use. Sometimes our training is "this is why [the children are] doing what they do" and gives us the science, but they don't ever give us the "and this is what you can do to help them" type of information. We need real world approaches. . . . Here are some ideas to help the child, what they might need, how you can handle the situation.* —Teacher

> *I wish we had more special needs training. I saw a brief 30-minute autism training, which barely scratched the surface. For special needs, we don't have a lot of that background. I think we are lacking that.* —Teacher

Summary of Chapter Findings

The survey and interview results presented in this chapter demonstrate that HS programs and EHS programs approach the staffing of the health services area in varied ways. Within this array of approaches, it is clearly the norm for the health manager to have other roles in their programs, although the health manager role is typically primary, and secondary roles are often related to the health services area (e.g., nutrition coordinator). Moreover, it is evident that the delivery of the health services area calls on the expertise of a wide array of HS/EHS program staff, from those working in the classroom with children to those reaching out to families through home visits and other interactions. Sometimes other staff members take responsibility for a health-related activity; in other cases, the health manager has the lead. Regardless, each program must identify the lines of authority and how coordination will occur. Moreover, this model of shared responsibilities can be problematic for some health managers who feel torn between their various responsibilities (see the earlier discussion in Chapter Three of job challenges).

Given the complexities of the health services area, having a knowledgeable team of staff coordinating health services is as vital as providing effective professional development opportunities for HS/EHS staff. Health managers appear to be making use of many of the opportunities they have for professional development, with training on multiple topics (those

without training are constrained by a lack of access). Most health managers also interact with their peers at least a few times a year, which can provide opportunities for further professional growth. Training on an array of health-related topics is also available for other staff in most HS/EHS programs, although there is variation in the prevalence of various topics. Most programs provide some supports, financial or otherwise, for health managers and other staff to partake of the available training. More in-depth conversations suggested that health managers are intentional about the trainings they pursue for themselves and their staff, and they work to make efficient use of the training resources they have. Health managers pointed especially to the value of training and mentoring when starting in the health manager role. Other HS/EHS staff interviewed identified the need for training to cover practical guidance.

Across these aspects of staffing and professional development for the health services area, we found few major differences between HS programs and EHS programs. Many topics considered in this chapter were part of one of the four supplements given to only one-quarter of health managers. As a result, we do not provide separate tabulations for Region XI and XII programs on those issues. Key differences for Region XI AIAN programs that we could identify include the higher incidence of a health manager who shares in other roles. Region XI programs also had a higher incidence of being able to communicate with children and parents in all primary languages (86 percent). Region XII MSHS programs stand out for having health managers who are most likely to exclusively focus on their health manager roles. In addition, health managers in Region XII programs were more likely to report having staff and consultants with expertise in the health-related customs, culture, and traditions of the families they serve. Related to professional development, health managers in both Region XI and Region XII programs were more likely to be isolated from their peers, with fewer opportunities for interaction with other health managers.

For the core survey questions where we could examine differences based on health manager and program characteristics, we identified a number of patterns worth highlighting. For example, as the health manager's health-related education increased, the health manager was less likely to serve in multiple roles. When combining roles, those without a health-related education background spent a smaller share of time on the health manager role and were more likely to have another role that was not health related. They were also less likely to have had contact with another health manager in the past year. We also found that health managers in smaller programs or in more-rural areas—compared with larger programs or more-urban programs, respectively—are more likely to serve in other roles in addition to the health manager. And when these health managers are in additional roles, they spend less time as health managers; they also have fewer contacts with health managers in other programs.

5. Health Services Advisory Committee and Policies for the Health Services Area

As noted in our organizational framework (see Figure 1.1), the HSAC is one of several key stakeholders in the Head Start health services area and plays several critical roles, including advising the health manager, providing technical expertise, and serving as a linkage to community partners. Although each program is required by the performance standards to have an HSAC, there is a paucity of representative information available about how HSACs are structured and operate across HS/EHS programs. The 1993–1995 Descriptive Study of Head Start Health Services (Keane et al., 1996) did not collect detailed information on these topics. To fill this gap, we aimed to collect information about the makeup of HSACs, the interactions between the health manager and the HSAC, and the ways the HSAC supports the health services area. At the same time, the study did not set out to determine whether HS/EHS programs are meeting specific requirements regarding the HSAC or its role.

Chapter Five Methods

- HS/EHS programs are the unit of analysis
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (module 1) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.
- Insights from the interviews with health managers and other staff and open-ended survey responses are integrated where relevant.

We begin in the next section with results on the structure, composition, and role of the HSAC. We then discuss the results of several questions, included in the supplemental questionnaire for the survey of health managers, specific to health-related program policies that were of interest to OHS. Regarding the HSAC, the most-salient findings include the following:

- In most HS/EHS programs, the health manager reported managing just one HSAC (73 percent), and most do not share their HSACs with another program (84 percent).
- The typical program has an HSAC with 15 members, but it is not uncommon for HSACs to have 20 or more members. On average, health managers reported that 70 percent of HSAC members are active. Health managers interviewed referenced the challenge of maintaining active engagement on the part of the HSAC members.
- Interviewed health managers reported a variety of strategies for recruiting members. The resulting HSAC membership shows that a wide range of expertise and community stakeholders are represented on HSACs. Most common are health care providers (medical and dental), parents and guardians, and HS/EHS administrators. Other frequent categories include other health experts, other HS/EHS staff, and individuals representing

other community organizations. Health managers almost universally reported feeling that their HSACs represent the relevant ethnic, cultural, and linguistic backgrounds of the families and children they serve.

- Interviewed health managers reported a variety of strategies for recruiting members, although maintaining active engagement on the part of members can be challenging.
- The majority of HSACs meet twice a year, and regular consultations between the health manager and HSAC members typically take place between meetings.
- Interviews with health managers revealed that health managers seek to tailor their committees to meet the specific needs of their programs. HSACs are often structured to encourage engagement and efficient operations. At the same time, interviewed health managers cited a need for training in effective strategies for optimizing the input from HSACs.
- Health manager survey respondents generally agreed that their HSACs support the development and maintenance of community partnerships, help programs stay abreast of issues and best practices, and support internal functions relating to health services and program policies and procedures.

We summarize our results regarding program health- and safety-related policies at the end of the chapter. Differences for Region XI and Region XII programs and by health manager and program characteristics are also reviewed at the end.

HSAC

Health managers were asked a number of questions as part of the Health Manager Survey about the structure and composition of their HSACs, as well as the role the HSAC plays in decisionmaking. These and other issues were explored further in the individual interviews.

Structure and Composition of the HSAC

As shown in Table 5.1, health managers in HS/EHS programs typically manage one HSAC, with just 27 percent responding that they are responsible for two or more HSACs. In addition, it is relatively rare that an HSAC is shared across two or more programs—just 16 percent of health managers indicated this arrangement. Among those that do share at least one HSAC, almost 65 percent shared with an EHS program, 74 with an HS program, 10 percent with a Region XII MSHS program, and 3 percent with a Region XI AIAN program. These HSAC structural features are very similar for HS programs and EHS programs, but there are some differences for Region XI and Region XII programs. In particular, health managers of Region XII MSHS grantees are more likely to manage multiple HSACs (43 percent versus 27 percent of HS/EHS programs overall) and to share their HSACs with another program (34 percent versus 16 percent overall). Among those MSHS health managers who share their HSACs, combining with another MSHS program is most common (72 percent). Health managers in Region XI AIAN grantees reported that they are less likely to have multiple HSACs, compared with health managers

overall (16 percent versus 27 percent). While Region XI AIAN grantees are somewhat less likely to share HSACs, those that do are most likely to share with another AIAN grantee (53 percent).

Table 5.1. HSAC Structure: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Number of HSACs managed (% distribution)					
1	72.9	72.4	73.9	84.0	57.6
2 or more	27.1	27.6	26.1	16.0	42.4
[Missing]	*3.9*	*3.9*	*3.7*	*4.4*	*0.6*
HSAC shared with another program (% distribution)					
No	83.6	85.2	80.6	89.1	66.4
Yes	16.4	14.8	19.4	10.9	33.6
[Missing]	*5.5*	*5.2*	*5.9*	*5.6*	*6.7*
If HSAC is shared, type of program (%, more than one may apply)					
With EHS program	64.8	62.4	68.0	69.6	28.7
With HS program	73.8	68.5	81.1	60.4	53.2
With MSHS program	10.1	11.6	8.1	0.0	71.7
With AIAN program	3.1	3.0	3.2	53.4	0.0
[Missing]	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

There are several interesting differences in the results in Table 5.1 based on program size and urbanicity (see Table H.5.1 in Appendix H). As program size increases, programs are more likely to have multiple HSACs (from 24 percent to 32 percent for small versus large programs), but there is not much difference, based on program size, in the likelihood of sharing the HSAC with another program (at 81 percent, 86 percent, and 84 percent, respectively, for small, medium, and large programs). Among those that do share their HSACs, larger programs are more likely to share with an EHS program (72 percent for larger programs versus 44 percent for small programs) or an MSHS program (16 percent for larger versus 4 percent for small), but less likely to share with an HS program (81 percent for small versus 65 percent for large). As urbanicity increases, programs are more likely to have more than one HSAC (14 percent for mostly rural versus 30 percent for mostly urban) and more likely to share their HSACs with another program (7 percent for mostly rural versus 21 percent for mostly urban). Mostly urban programs that share their HSACs do so at a greater rate with EHS and HS programs (66 to 80 percent for mostly urban programs versus 39 to 49 percent for mostly rural ones) but have a much lower rate of sharing with an MSHS or AIAN program (3 to 4 percent for mostly urban programs versus 16

to 32 percent for mostly rural ones). There are no substantial differences in these patterns based on the health manager's health-related education background.

Health managers reported on the number of HSAC members and the number of active HSAC members, defined in the survey as those members "who regularly engage in their role as a member of the HSAC." Table 5.2 records the mean and median membership for these two indicators, as well as the percentage distribution across different size categories. Overall, the typical program (the one at the median) has 15 members on the HSAC, while the average membership is about 20 people. But almost 20 percent of grantees have 26 or more HSAC members, so some committees are quite large. About 70 percent of members were reported as active. These patterns are very similar for HS programs and EHS programs. However, Region XI HSACs tend to be smaller, with ten members at the median, while Region XII HSACs tend to be larger, with 17 members at the median. The percentage of members considered to be active does not vary much across the program types.

Table 5.2. HSAC Size: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Number of HSAC members					
Mean number	19.7	19.3	20.5	13.9	23.7
Median number	15.0	15.0	16.0	10.0	17.0
Percent distribution (%)					
Up to 10	26.0	27.4	23.6	57.6	22.9
11 to 15	24.6	24.8	24.4	19.2	23.1
16 to 20	18.0	17.5	18.9	12.3	13.4
21 to 25	12.3	12.5	12.0	4.6	11.0
26 or more	19.1	17.9	21.2	6.3	29.6
[Missing]	*6.8*	*6.7*	*7.0*	*8.1*	*9.5*
Number of active HSAC members					
Mean number	12.9	12.5	13.5	9.4	16.0
Median number	10.0	10.0	10.0	8.0	10.0
Percentage distribution (%)					
Up to 10	53.3	54.6	51.0	78.1	55.1
11 to 15	22.0	22.2	21.7	8.8	9.9
16 to 20	13.5	13.1	14.3	6.5	10.3
21 to 25	5.8	5.6	6.3	3.6	5.8
26 or more	5.4	4.6	6.8	3.1	18.9
[Missing]	*6.5*	*6.5*	*6.6*	*8.1*	*6.1*
Share of members who are active					
Mean percentage (%)	70.0	70.9	68.4	72.4	67.2
Median percentage (%)	66.7	66.7	66.7	71.4	71.4
[Missing]	*7.2*	*6.9*	*7.5*	*8.1*	*9.5*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions and summary statistics are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

As might be expected, the mean and median number of HSAC members increases with program size (mean of 17 members for small programs and 23 members for large ones) and in moving from programs in mostly rural areas to programs in mostly urban ones (mean of 14 members for mostly rural programs and 21 members for mostly urban ones) (see Table H.5.1 in Appendix H). The same pattern holds for the number of active members. However, there is no clear pattern by program size or rural-urban status in the share of the membership that is active. There are no important differences in the number of HSAC members and the share of active members based on the health manager's health-related education background.

Health managers were asked to indicate which types of individuals were members of HSACs, with 24 possible categories, as shown in Table 5.3. The responses indicated broad-based membership, with an average of 11 categories of members selected (and a range from one to 24 categories selected). Membership is made up of those with direct ties to the HS/EHS program (e.g., administrators, classroom staff, other staff, parents) and those without such ties but otherwise contributing a range of expertise and organizational affiliations. Most HSACs included medical care providers (90 percent), parents or guardians (88 percent), program administrators (87 percent), oral health care providers (83 percent), and nutritionists (81 percent). Somewhat less common were such individuals as members of public health departments or boards (76 percent), mental health staff members (74 percent), WIC or other community food or nutrition services (71 percent), health educators on staff (68 percent), family service workers (61 percent), behavioral health providers (60 percent), and disability specialists (50 percent). Among the options given, least common were cultural/community healers (2 percent), cultural liaisons (3 percent), representatives of migrant health services organizations (6 percent), and Indian Health Service (IHS) representatives (8 percent). While those last two categories were rare across all HS/EHS programs, they were much more common for Region XI AIAN grantees (where IHS representatives are on HSACs for 79 percent of grantees) and for Region XII MSHS grantees (where migrant health services representatives are on the HSAC for 61 percent of grantees).

There are some differences with program size and rural-urban status in the likelihood of certain types of representation on the HSAC (see Table H.5.3 in Appendix H). In many cases, larger programs and programs in urban areas are more likely to have representation from any given category listed in Table 5.3, but that also reflects the larger membership of their HSACs. Effectively, larger programs and those in mostly urban areas, because of their larger HSAC membership, are able to operate HSACs with more-varied representation (e.g., nutritionists, mental health specialists, oral health care providers, disability specialists). There are some exceptions, however. For example, there is no difference by program size or rural-urban status in the likelihood of having representation from various categories of HS/EHS staff (e.g., program administrators, family service workers), Part B and Part C partners, and medical providers. The reverse pattern also holds, such as smaller programs and those in mostly rural areas being more likely to have an IHS representative because of the association between those characteristics and Region XI AIAN programs.

Table 5.3. HSAC Member Composition and Representation: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Groups represented on the HSAC					
Average number reported (*N*)	11.3	11.2	11.5	10.5	11.4
Percentage for each group (%)					
HS/EHS program staff					
Program administrators	87.2	87.5	86.5	85.8	73.8
Family service workers	60.8	61.5	59.5	61.3	52.7
Teachers, teachers aides, or other classroom staff	28.7	29.7	27.0	28.9	25.4
Nutritionists, nutrition experts	80.5	80.7	80.0	65.8	71.4
Mental health staff	73.6	74.1	72.8	68.0	64.1
Health educators	68.0	67.3	69.4	69.4	65.7
Other HS/EHS staff	24.5	22.9	27.5	6.0	19.6
Community members					
HS/EHS staff from another program	22.8	20.6	26.6	14.5	21.6
Parents/guardians	87.9	88.7	86.5	68.0	86.4
Medical care providers	90.2	89.7	91.2	92.4	88.1
Oral health care providers	82.8	83.4	81.9	86.9	76.2
Behavioral health providers	59.5	60.9	57.1	66.1	46.2
Disability specialists	50.0	49.1	51.6	36.0	59.1
Migrant health services	6.2	6.6	5.6	1.6	61.2
IHS	8.2	9.1	6.7	79.4	0.6
Cultural/community healer	1.8	1.9	1.5	6.2	1.3
Public health departments/boards of health	75.7	75.2	76.6	42.4	86.6
WIC or other community food or nutrition service	71.4	69.9	74.0	61.8	71.8
Part B and C partners	19.8	16.6	25.5	10.6	33.1
School district LEA	35.8	35.8	35.7	21.4	51.6
Cultural liaisons	2.7	2.8	2.5	16.4	2.8
Advocacy groups	19.5	18.2	21.7	8.9	18.4
Other social services providers	40.9	38.7	44.8	30.1	42.0
Other local government agencies or officials	20.5	20.0	21.2	14.6	15.5
Other	10.4	9.7	11.7	8.8	5.6
[Missing]	*5.4*	*5.3*	*5.8*	*5.6*	*6.7*
HSAC members have similar racial, ethnic, cultural, and linguistic backgrounds as children and families served[a] (% distribution)					
Represent all/most backgrounds	56.4	56.3	56.7	–	–
Represent some backgrounds	39.7	39.4	40.1	–	–
Do not represent backgrounds	3.9	4.3	3.2	–	–
[Missing]	*6.9*	*6.7*	*7.3*	–	–
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference. – = Question in survey supplement; results not reported.
[a] Based on 373 health manager respondents for 486 programs in Supplement A. Results not reported for Region XI or Region XII programs.

As part of a supplemental question, also reported in Table 5.3, 56 percent of health managers reported that their HSAC members represent all or most ethnic, cultural, and linguistic backgrounds of the children and families they serve. Just 4 percent said that the HSAC did not represent the relevant backgrounds. These shares were very similar for HS programs and EHS programs.

Role of the HSAC

Health managers reported on their consultations with their HSACs, as shown in Table 5.4. Almost all HS/EHS programs have regular meetings with their HSACs, with the majority (57 percent) meeting two times a year and a somewhat smaller share meeting even more frequently (34 percent). In addition to these structured interactions, most health managers reported in a supplement question that they regularly consult with HSAC members or the committee as a whole at other times, typically about once every two to three months (33 percent); for some, this frequency is higher—specifically, once a month (24 percent) or two to three times a month (19 percent). Just 11 percent of grantees rarely consult with HSACs apart from the regular meetings. Table 5.4 also shows that, as reported in another supplement question, 63 percent of grantees have their HSACs participate in the annual self-assessment. For the most part, these patterns of consultation are very similar across the program types shown in Table 5.4. There is some indication that Region XI AIAN HSACs meet even more often than the average, with more than one-half of Region XI grantees meeting with their HSACs more than twice a year.

Differences in the frequency of HSAC meetings (the one core survey question in Table 5.4) are limited to program size and rural-urban status (see Table H.5.4 in Appendix H). Larger programs and ones in mostly urban areas are somewhat more likely to report meeting twice a year or more, compared with smaller programs and ones in mostly rural areas, but the differences are not particularly sharp. There is no clear relationship between the health manager's health-related education background and the frequency with which the HSAC meets.

A final supplemental question asked health managers about their agreement with 11 statements about the functioning of their HSACs. Ratings ranged on a five-point scale from "strongly agree" to "strongly disagree." The percentage distribution of responses across the five response categories is shown in Table 5.5 for each of the statements, aggregated across all HS/EHS programs. For each statement, a strong majority either agreed or strongly agreed with the statements; the share that disagreed or strongly disagreed never exceeded 15 percent and was typically less than 5 percent.

Table 5.4. HSAC Consultation and Role in Annual Self-Assessment: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Frequency of HSAC meetings (% distribution)					
Never (do not formally meet)	0.6	0.5	0.7	1.5	2.9
Once a year	7.9	8.4	7.2	3.1	12.9
Twice a year	57.4	58.5	55.4	39.6	55.6
Every two to five months	31.6	29.8	34.9	42.0	28.6
Every month or more	2.4	2.8	1.7	13.8	0.0
[Missing]	*5.5*	*5.2*	*6.0*	*8.2*	*4.0*
Frequency consult with HSAC outside of regular meetings[a] (% distribution)					
Several times a week	5.4	5.1	6.0	–	–
About once a week	7.2	9.0	3.9	–	–
Two to three times a month	19.2	19.8	18.2	–	–
About once a month	24.3	24.4	24.1	–	–
About once every two to three months	32.7	31.8	34.4	–	–
Rarely apart from regular meetings	11.2	9.9	13.4	–	–
[Missing]	*7.2*	*6.7*	*7.9*	–	–
HSAC participates in annual self-assessment[a] (% distribution)					
Yes	63.1	63.6	62.4	–	–
No	36.9	36.4	37.6	–	–
[Missing]	*9.0*	*8.7*	*9.4*	–	–
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.
[a] Based on 373 health manager respondents for 486 programs in Supplement A. Results not reported for Region XI or Region XII programs.

The strongest support was for the statement that the HSAC "helps to establish ongoing, collaborative partnerships with community organizations," with almost 90 percent agreeing or strongly agreeing with that statement. Support was nearly equal that the HSAC "informs us about current and emergent health issues, trends, and best practices" (88 percent agreeing or strongly agreeing). Health managers for 70 percent or more of programs agreed or strongly agreed with other statements about HSACs supporting more-internal functions of HS/EHS programs, such as helping to develop policies and procedures, helping to find continuous accessible care and treatment services for children and families, helping parents and guardians in being advocates for their children's health, and helping with programs' community assessment and ongoing monitoring activities. Support was similarly high for statements about external supports, such as serving as educators about the needs of and issues facing HS/EHS children and families and advocating for community-system changes that support HS/EHS clients. The lowest level of support was for the statement that the HSAC "develops comprehensive health promotion

programs for HS/EHS children, families, and staff," although 61 percent still agreed or strongly agreed with the statement.

Table 5.5. Health Manager View of HSAC Functioning: All Program Types

Statement	Percentage Distribution				
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Informs us about current and emergent health issues, trends, and best practices	47.4	41.0	8.9	2.4	0.3
Develops long- and short-term goals and objectives and strategies for implementing HS/EHS services and activities that meet the needs of the community	21.9	44.6	23.3	8.1	2.3
Helps to develop health policies and procedures (e.g., policies on how health screenings are conducted, how health activities are implemented that support the health goals for HS/EHS children, families, and staff)	34.6	49.8	10.4	4.2	1.0
Develops comprehensive health promotion programs for HS/EHS children, families, and staff	19.4	41.4	26.8	11.2	1.3
Advocates for community systems changes that support the health of the children and families in your program	28.4	49.0	18.1	4.0	0.6
Helps with or participates in your program's community assessment and ongoing monitoring activities	27.7	45.5	16.9	9.2	0.7
Helps to find continuous, accessible care and treatment services for children and families	30.7	47.6	17.8	3.6	0.3
Supports parents/guardians in becoming advocates for their children's health	31.7	51.0	14.7	2.6	0.0
Supports parents/guardians as leaders in efforts to improve the health of their community	26.5	46.7	22.8	4.0	0.0
Helps to establish ongoing, collaborative partnerships with community organizations	40.0	49.7	9.2	1.1	0.0
Educates health care providers, other professionals, and community leaders or policy makers on the needs and issues of HS/EHS/MSHS/AIAN children and families	33.9	46.6	17.0	2.2	0.3

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 373 health manager respondents for 486 programs in Supplement A. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases ranges from 8 to 9 percent, depending on the statement.
– = not reported.

Additional Perspectives from Health Managers on the HSAC

HSAC structure and operations, membership, and roles and responsibilities were topics covered by our interviews with health managers. Our interviews with staff in other roles also touched on the HSAC, although the vast majority of other staff reported having no interaction with or insight about the utility or effectiveness of the HSAC.

HSAC Structure and Operations

Most health managers settled on their current HSAC format after a series of "trial and error" approaches. For example, several health managers noted that in addition to the in-person meetings, they had more-frequent informal or one-on-one interactions with members of HSACs on a more regular basis. In this model, individual members would work with the health manager to address emergent issues or concerns related to their areas of expertise.

While some HS/EHS programs share an HSAC, this was not a model that was widely cited in our interviews (nor overall, as seen in Table 5.1). One health manager noted that she sits on the HSAC of another program, and vice versa, but because one program is specific to Early Head Start and the other to Head Start, it did not make sense to combine the HSACs, given different areas of focus and expertise needed. One innovative model raised by a few health managers involved merging their HSACs with other similar boards in the community. In both instances, the programs were in smaller or rural areas, where the number of community experts is limited. In those settings, the same experts were being tapped for similar boards, and it was hard to recruit these individuals for multiple boards. These communities developed a novel approach and combined similar board meetings, where experts regularly meet in person to obtain feedback and provide input on each other's programs and efforts. Health managers reported that this model is very successful in that the number of meetings for any one individual is drastically reduced, and there is greater information sharing and linkages with other community organizations with a similar mission.

Health managers working with a more traditional HSAC structure also reported that allowing time for all HSAC members to provide an update on their organizations and elicit feedback from the rest of the committee was seen as very beneficial and promoted buy-in among HSAC members. Consistent with the more community-integrated HSAC models described above, one health manager noted that coming to the meeting with a list of questions and decision points for the committee, rather than a status report, improved participation and engagement among her committee by showing them that their time and expertise was valued.

> *We get an idea of what each of us are doing since we share a committee and give each other ideas. Sometimes we have resources that are available that they didn't know about and vice versa.* —Health manager

> *A portion of the meeting is for Head Start business and then we have an open table meeting where folks update the group on what is going on in their agency.* —Health manager

If [HSAC members] just sit there and don't feel like they are participating, they are not likely to come back. I frame the agenda more in terms of specific questions to the group, which makes them more engaged. —Health manager

Identification and Recruitment of Members

Health managers reported identifying and recruiting HSAC members using a variety of methods. In many cases, health managers draw on their personal or professional contacts, and others reported attending different community meetings and identifying potential members. Providers who were working with the HS/EHS program to address the health needs of a child, or who served a large proportion of children, were often asked to join as well. Some health managers reported a high turnover rate of their HSAC members. One program reported asking their departing members to find replacements for themselves from within their practice or organization to ensure continuity in expertise. Health managers consistently reported, however, that identifying committee members and maintaining their active involvement take a lot of time and are a significant challenge and consistent struggle. Some provider specialties, such as dentists, are the most challenging to recruit.

Nearly every addition I have made to the HSAC was due to a personal connection. We also had a dentist who had a family cancel on them seven times. [The dentist] called me to find out what was going on, so I educated [the dentist] about the challenges these families face, and [the dentist is] now on board and [has] joined the HSAC. —Health manager

We feel fortunate that we have the group we do, but we are frustrated that we don't have representation from some critical areas, such as dental. I have tried to talk with them, sent them a brochure, etc. but no bites. We are trying to get more agencies involved overall. —Health manager

Parent Involvement

Ideally, HSACs should have representation from parents or guardians. All health managers noted that the parents who do volunteer feel quite comfortable participating and are well respected by other HSAC members. Their perspectives are highly valued, and community members often probe them for more information and perspectives on the topics under discussion. Parents also find added value in that they are able to speak with a wide range of experts to get advice before or after the meetings. The primary challenge health mangers confront is in the identification of a parent or two willing to serve in this capacity. Health managers noted that most parents do not feel that they have the time to participate. Some programs provide transportation and meals for parents who participate, in an effort to ensure attendance.

I feel really good about our parents. We hold meetings in a round circle. We provide a meal, and it feels comfortable. We let them know their input is welcome and needed. The physician and dentist are very "pro parent." —Health manager

We start out by looking for volunteers from our parent council. Our chief executive officer also discusses the need to have parents involved so they know that they have a voice at the table. When they come to the meeting, they are

introduced as a parent representative. Typically they are quiet at the first meeting, but after that they can be vocal. Our difficulty is attendance, but when they are there, they are vocal. —Health manager

Training on HSAC Management

In addition to the challenges of identifying and sustaining participation from both community partners and families, health managers noted additional challenges related to the HSAC. Some health managers reported a need for more training and guidance around how to organize and run an HSAC, particularly in unique settings (e.g., rural areas that span multiple counties and hundreds of miles). While our findings suggest that there is not one right way to manage an HSAC, this need may be met by fostering connections across health managers, as well as sharing lessons learned and best practices. This finding is consistent with the need for general health manager training identified by health managers in Chapter Four and could potentially be included in a more comprehensive health manager training.

Program Policies

Several questions about health- and safety-related policies of interest to OHS were included in the online survey of health managers. These questions were part of the supplemental survey and therefore asked of about one-quarter of the respondents. For this reason, we do not show separate results for the small number of Region XI and XII health managers who were asked these questions.

Health-Related Policies

Health managers were asked whether their programs have health-specific goals or objectives as part of the programs' school-readiness plans. As shown in Table 5.6, nearly all HS/EHS programs (90 percent) reported that they have such goals, a share that is very similar for both HS programs and EHS programs.

The overweight and obesity rate is rising among young children, so Table 5.6 also shows the nature of the program's policy with respect to the number of minutes per day that children should take part in physical activity. The most common response was 30 to 59 minutes (40 percent), followed closely by 60 or more minutes per day (37 percent). Just 14 percent of programs are reported to have no policy in this regard. While HS programs show a similar pattern, health managers for EHS programs were less likely to have a policy in this regard (20 percent with no policy versus 11 percent for HS programs).

Safety-Related Policies

Several policies with respect to safety were also asked about in the Health Manager Survey, as part of the survey supplement. First, health managers were asked how they track Consumer Product Safety Commission (CPSC) recalls or regulations, with multiple answers allowed among

the response categories (see Table 5.7). Overall, health managers selected an average of about two methods used (ranging from one to six). The most common response (49 percent) was using the Early Childhood Learning and Knowledge Center (ECLKC), an Internet-based repository of resources supported by OHS. Receiving emails directly from the CPSC was the second most common answer (39 percent), and OHS emails (35 percent) was third. Other approaches were less likely to be used. Just 12 percent of programs reported that they did not track CPSC recalls or regulations. For the most part, these same patterns hold for both HS programs and EHS programs, although the latter are somewhat less likely to not track regulations or recalls.

Table 5.6. Health-Related Policies: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Program has health-specific goals or objectives in school-readiness plan (% distribution)			
Yes	89.5	87.2	93.5
No	10.5	12.8	6.5
[Missing]	*8.2*	*7.9*	*8.7*
Minutes per day children should take part in physical activity (% distribution)			
Less than 15 minutes	0.6	0.7	0.5
15 to 29 minutes	8.4	8.0	9.2
30 to 59 minutes	39.8	42.3	35.3
60 or more minutes per day	37.1	38.0	35.4
Program does not have a policy	14.1	11.0	19.6
[Missing]	*8.4*	*7.7*	*9.7*
Number of health manager respondents	373	331	205
Number of programs	486	300	186

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Two other supplemental questions addressed approaches for ensuring that children are not left alone in a classroom (see Table 5.8) or on a bus or van (see Table 5.9). Across these two tables, we see that very few programs have no policy at all in this regard (fewer than 5 percent). Rather, programs rely on multiple strategies with high rates of utilization. On average, with regard to safety in the classroom, health managers selected seven methods (ranging from one to ten). The most common responses, in use by 60 percent of programs or more, include procedures for counting children and for conducting visual checks at key transition points. Providing annual staff training is also a strategy used by 70 percent or more of programs. These same general strategies are also followed for transportation safety, where five methods were selected on average (ranging from one to eight methods). In most cases, the prevalence of these practices is higher in HS programs than in EHS programs, which may reflect the differences in the care environment and activities for preschool-age children versus infants and toddlers.

Table 5.7. Product Safety-Related Policies: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
How program tracks CPSC recalls or regulations			
Average number reported (*N*)	2.4	2.3	2.6
Percentage for each method (%)			
Emails directly from the CPSC	38.8	35.3	45.1
Checking the CPSC website	28.3	27.6	29.5
The ECLKC	48.8	47.0	51.8
OHS information memoranda	26.0	24.3	29.0
OHS emails	35.3	35.0	35.7
OHS newsletters	22.9	21.7	25.0
Other approach	12.0	12.2	11.7
Program does not track CPSC recalls or regulations	11.9	14.4	7.5
[Missing]	*7.7*	*7.1*	*8.7*
Number of health manager respondents	373	331	205
Number of programs	486	300	186

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Table 5.8. Policies for Ensuring That Children Are Not Left Alone in Classroom: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
How program ensures that children are not left alone in classroom or another part of the facility			
Average number reported (*N*)	7.4	7.6	7.0
Percentage for each method (%)			
Phones are in all classrooms for staff to call if they need to step out	58.3	59.4	56.4
A count of children entering the classroom is kept and used to count each child exiting the classroom	81.5	84.8	74.9
Staff conduct a walking and visual sweep of classroom	81.0	84.5	74.0
Staff wait for all children to leave the bathroom before leaving	72.5	76.4	64.7
Staff count the number of children in the classroom after children have come back from the bathroom	64.8	68.3	58.2
Staff conduct a walking and visual sweep of the bathroom	69.8	73.5	62.4
Staff conduct a walking and visual sweep of the playground	79.9	83.2	73.5
Staff count the number of children before leaving the playground	83.5	87.1	76.4
Staff receive training at least once a year in how to ensure that children are not left alone	73.8	77.3	67.0
Other approach	7.4	5.1	12.0
Program does not have a policy or standard guidance	4.6	5.9	2.0
[Missing]	*8.6*	*7.5*	*11.0*
Number of health manager respondents	373	331	205
Number of programs	486	300	186

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference. Excludes 14 health managers responding for 15 programs that do not operate in a classroom setting.

Table 5.9. Policies for Ensuring Children Are Not Left Alone on Bus or Van: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
How program ensures children are not left alone in bus or van			
Average number reported (*N*)	5.1	5.1	5.1
Percentage for each method (%)			
Lines of communication are available (e.g., radio, cell phone) in all buses/vans for drivers to call if they need to leave the bus/van	78.8	81.3	74.0
A count of children entering the bus/van is kept, and this number is used to count each child as they exit the bus	80.8	82.8	76.9
The bus/van driver or bus/van assistant or aide does a walking and visual sweep of the bus, including the floor	83.9	86.9	78.2
A teacher/teacher assistant does a walking and visual sweep of the bus, including the floor	54.9	54.9	55.1
Teachers/teachers assistants receive training at least once a year in how to ensure that children are not left alone	71.1	72.5	68.3
Bus/van drivers and/or bus/van assistants or aides receive training at least once a year in how to ensure that children are not left alone	80.4	83.1	75.2
Other approach	8.2	6.5	11.4
Program does not have a policy or standard guidance	1.6	2.2	0.7
[Missing]	*9.9*	*8.2*	*13.3*
Number of health manager respondents	373	331	205
Number of programs	486	300	186

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference. Excludes 81 health managers responding for 103 programs that do not transport children.

Summary of Chapter Findings

Health manager survey and interview results indicated that HSACs serve a vital role in connecting HS/EHS programs to health-related resources in the community and other valuable expertise. While medians and averages provide some sense of the typical program's HSAC, there is considerable variability across programs in how HSACs are structured, the composition of the members, and the roles they play. Health managers often select members and organize HSACs to meet the needs of their programs. Such tailoring further ensures the usefulness of the HSACs. Health managers themselves may benefit from having more training on how best to structure and maintain their HSACs.

The role of the HSAC is generally similar for Region XI AIAN and Region XII MSHS programs. Those differences that do exist may be attributable to the specific nature of these programs. Region XI HSACs tend to be somewhat smaller, and the reverse is true for Region XII. In Region XII MSHS programs, it is more common for the health manager to manage multiple HSACs and to share their HSACs with other programs, typically other MSHS programs.

For the core survey questions, our analyses showed some differences in the structure of the HSAC, particularly based on program size and rural-urban status, with mostly rural programs

being less likely to have multiple HSACs and both smaller programs and mostly rural programs less likely to share their HSACs. For mostly rural programs, sharing HSACs with AIAN or MSHS programs is relatively more common, whereas mostly urban programs are more likely to share with HS and EHS programs. The size of the HSAC generally increases with program size and urbanicity, but the share of members who are active does not vary substantially by these two characteristics. Because larger programs and more-urban ones have larger HSACs, they are also more likely to have a broader set of representatives on their committees (e.g., nutritionists, mental health specialists, oral health care providers, disability specialists), but there also appear to be certain types of representation for which the likelihood of HSAC membership does not vary with program size or rural-urban status (e.g., HS/EHS staff, Part B and Part C partners, and medical providers). In terms of process, there is a tendency for larger programs and ones in mostly urban areas to meet more often with their HSACs. For the most part, the structure, composition, and functioning of the HSAC does not appear to vary with the health-related education background of the health manager.

This chapter also reported on survey responses to several questions regarding health- and safety-related program policies. Those responses show that almost all HS/EHS programs have health-specific goals or objectives as part of their school-readiness plans. For the most part, programs have a policy in place regarding the required amount of physical activity, and most specify at least 30 minutes per day. Programs also rely on multiple strategies for tracking product recalls or cancellations and for ensuring that children are not left alone in the classroom or on the bus.

6. Health Issues for HS/EHS Children and Families

Chapter One highlighted some of the health challenges facing HS/EHS children and families that serve, in part, to demonstrate the need for the comprehensive health services provided by HS/EHS programs. While there is an extensive literature that documents the incidence of the health conditions relevant for children and families in poverty, this chapter places a spotlight on the most-pressing health issues identified by HS/EHS health managers as part of the Health Manager Survey (module 3). Their understanding of the relevant issues serves to shape the health-related services and programming that health managers plan for, implement, and monitor. In addition to the survey-based findings, our interviews with health managers explored a topic not covered in the online survey but relevant in the context of health management: serving medically fragile children or those living with chronic conditions. We include a section addressing this topic as part of this chapter.

Chapter Six Methods

- HS/EHS programs are the unit of analysis.
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (module 3) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups, defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.
- Insights from the interviews with health managers and other staff and open-ended survey responses are integrated where relevant.
- Data from the PIR contain all programs in the survey frame and are unweighted.

We also draw on information reported in the PIR about health insurance coverage and access to continuous, accessible health and dental care, as it helps to provide context for understanding the resources available to HS/EHS children and families to meet their health care needs. Data from the PIR contain all HS/EHS programs in our survey frame from the 2012–2013 program year (although a few programs have missing data), so PIR tabulations are unweighted. Disaggregated results are also presented for the PIR-based measures.

We begin with Health Manager Survey responses regarding the health issues facing their programs' children and families. We then summarize the PIR administrative data regarding health insurance coverage and medical and dental care access. Important findings from these analyses include the following:

- On average, health managers identified about seven major health concerns for the children in their programs. At the top on the list of concerns was overweight and obesity (selected by 86 percent of programs), followed closely by tooth decay (84 percent),

asthma or other lung disease (83 percent), and developmental delays (80 percent). A number of other behavioral and mental health concerns also receive frequent mention.

- The high rate of concern with overweight and obesity is consistent with data from the PIR, which shows that the average percentage of overweight or obesity among preschool-age children in HS programs is 29 percent. (This information is not recorded in the PIR for infants and toddlers.)
- The top-rated child health concerns are also the ones that require the most amount of the health manager's time. Across all HS/EHS programs, health managers reported an average of 20 hours per week in service coordination to address these concerns.
- Slightly fewer than one-half of all HS/EHS programs reported having one or more children living with a chronic health condition who would benefit from additional supports but are not eligible for Individuals with Disabilities Education Act (IDEA) Part B or Part C services. Relevant conditions included undiagnosed or early indication autism, ADHD or ADD, and asthma or other lung disease.
- Health managers reported an average of six important health issues that affect the adults in the families they serve. As with children, overweight and obesity tops the list as the most prevalent issue (77 percent), with high rates of mention as well for smoking (64 percent), low health literacy (60 percent), alcohol (48 percent), depression (47 percent), and family violence (47 percent).
- Data from the PIR for 2012–2013 generally show near-universal health insurance coverage for children in HS/EHS programs, with an increase from 94 to 97 between the start and end of the program year. Medicaid and SCHIP are the dominant sources of coverage. This pattern of high rates of coverage that increase over the program year is also the pattern of health insurance coverage for pregnant women in EHS programs.
- PIR data further indicate that most HS/EHS children have a medical home (94 percent at enrollment and 97 percent at the end of the Head Start enrollment year), "an ongoing source of continuous, accessible health care." Access to a dental home—"continuous, accessible dental care provided by a dentist"—is somewhat lower (76 percent at enrollment and 87 percent at the end of the enrollment year).

The concluding section highlights any differences in these key findings, where they could be examined, for programs in Region XI and Region XII, as well as differences by health manager background and program characteristics.

Health Issues for HS/EHS Children

The Health Manager Survey included several questions about the health issues facing children in their programs. This included an enumeration of specific health concerns, as well as responses regarding chronic health conditions and services under Part B and Part C of IDEA.

Importance of Specific Health Issues for Children

Health managers were asked to identify the "major health concerns" facing the children and families in their HS/EHS programs. Table 6.1 provides the list of physical health issues (12 issues) and behavioral health issues (nine issues) that were listed on the survey; health managers

could select multiple issues. On average, as shown in the table, about seven health issues were selected as major concerns (ranging from one to 21 selections). For each health issue, Table 6.1 also reports the percentage of HS/EHS programs where the health manager selected the issue as a major concern. Note that the percentages in Table 6.1 do not equate to the incidence of the health issue among the children served by Head Start; rather, the table reports the share of programs where the issue is identified as a major health concern.

Table 6.1. Program-Reported Major Health Concerns for Children in HS/EHS: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Health conditions facing children in the program reported to be major concern					
Average number reported (*N*)	7.2	7.1	7.3	7.7	6.8
Percentage of programs reporting each health condition as a major concern (%)					
Physical and oral health					
Overweight and obesity (BMI above the 85th percentile)	85.7	88.8	80.1	79.6	98.0
Tooth decay or cavities	84.3	85.7	81.6	92.1	94.2
Asthma or other lung disease	82.7	83.5	81.1	63.5	76.4
Vision conditions	30.3	32.0	27.1	32.5	22.3
Ear infections	30.1	26.0	37.7	53.6	36.8
Anemia (e.g., sickle cell, low iron)	24.8	21.9	30.2	24.5	30.6
Hearing conditions	23.2	21.7	25.8	31.8	20.6
Underweight or stunting or failure to thrive	19.6	17.6	23.2	12.9	25.5
Diabetes	13.3	13.4	13.3	26.4	14.5
Other health problem	9.8	8.7	11.7	1.3	4.6
Lead poisoning	9.8	9.5	10.4	10.9	10.9
Infectious diseases (e.g., HIV, TB)	3.9	3.6	4.4	3.5	20.5
Behavioral health					
Developmental delays (including language delays)	80.3	79.2	82.3	77.2	81.4
ADHD or ADD	47.2	50.6	41.0	46.5	26.2
Autism spectrum disorders	42.6	42.1	43.4	34.3	25.9
Child neglect or abuse	41.1	39.6	43.7	58.0	22.9
Family violence	36.2	34.4	39.3	42.7	28.1
Anxiety (including OCD)	19.0	19.2	18.7	26.5	17.3
Depression	15.8	14.1	18.8	21.0	14.4
Other behavioral health problem	10.5	10.4	10.6	17.1	7.2
PTSD	8.2	8.0	8.5	10.0	4.5
[Missing]	*5.6*	*5.2*	*6.3*	*9.9*	*4.0*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Response categories have been reordered from highest to lowest prevalence among all HS/EHS programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.
BMI = body mass index; OCD = obsessive-compulsive disorder.

Across all HS/EHS programs, the health concern that received the most "votes" was overweight and obesity, selected by health managers in 86 percent of programs. A similar share of programs (84 percent) selected tooth decay or cavities, followed closely by asthma or other lung disease (83 percent of programs). These three physical or oral health issues are closely matched by the percentage of programs where developmental delays, including language delays, was selected as a major health concern (80 percent of programs, making it the top-ranking behavioral health concern). After the top four concerns, the next most prevalent child health issues all fall into the behavioral health category: ADHD or ADD (selected by 47 percent of programs), autism spectrum disorders (marked by 43 percent of programs), child abuse or neglect (chosen by 41 percent of programs), and family violence (selected by 36 percent of programs). Other physical health concerns that were cited as major concerns by 20 to 30 percent of programs include vision conditions (30 percent), ear infections (30 percent), and hearing conditions (23 percent). The remaining issues—including diabetes, lead poisoning, infectious diseases (e.g., HIV, TB), depression, and PTSD—were marked as major issues for fewer than 15 percent of programs.

For the most part, the health issues cited as major concerns are similar for HS programs and EHS programs, although there are a few differences that correspond to the evolution of health issues as children age. For instance, compared with EHS programs, HS programs were more likely to mention overweight and obesity (89 percent versus 80 percent) and ADHD or ADD (51 percent versus 41 percent). At the same time, EHS programs were more likely to mention ear infections (38 percent versus 26 percent).

Compared with all HS/EHS programs, Region XI AIAN programs were less likely to mention overweight and obesity (80 percent versus 86 percent of programs) and asthma (64 percent versus 83 percent of programs) but more likely to cite child abuse and neglect (58 percent versus 41 percent), ear infections (54 percent versus 30 percent of programs), and diabetes (26 percent versus 13 percent of programs). For Region XII MSHS programs, the conditions with relatively more mentions, compared with all HS/EHS programs, include two physical health conditions—overweight and obesity (98 percent versus 86 percent) and tooth decay or cavities (94 percent versus 84 percent). But mentions were lower for three behavioral health conditions—child abuse and neglect (23 percent versus 41 percent), ADHD or ADD (26 percent versus 47 percent), and autism (26 percent versus 43 percent). It is important to keep in mind that such differences reflect the perceptions of the concern for a particular health issue by health managers in different types of programs and might not correspond to differences in the actual incidence of the health issue for HS/EHS children.

This same caveat applies when examining the patterns of health concerns reported by health managers when programs are classified based on health manager health-related education background, program size, and rural-urban status (see Table H.6.1 in Appendix H). There are some conditions, such as asthma and family violence, that are more likely to be major concerns among programs where the health manager has a health-related bachelor's degree versus no

degree. Such differences may reflect underlying differences that are associated with health manager background. Health managers in larger programs were more likely to mention overweight and obesity as a major concern, compared with health managers in smaller programs, but there is no difference in the percentage rating this condition as a health concern based on the program's rural-urban status. Larger programs and more-urban programs were more likely to rate asthma and autism as concerns. On the other hand, smaller programs and more rural ones were more likely to mention ear infections as a major concern. Some conditions were equally likely to be rated as a concern regardless of program size or rural-urban status (e.g., vision and hearing conditions, family violence).

The fact that overweight and obesity was selected as a major health concern by more than 85 percent of programs is consistent with data from the PIR. At enrollment, measurements on weight and height for enrollees age three and older (HS programs only) are used to report whether the child's BMI classifies him or her as underweight (BMI below the fifth percentile for the child's sex and age), healthy weight (BMI at or above the fifth percentile but below the 85th percentile), overweight (at or above the 85th percentile but below the 95th percentile), or obese (BMI at the 95th percentile or higher). Table 6.2 reports the average percentage distribution of children across these four categories and shows that the average percentage of children who were overweight or obese at enrollment in HS programs is nearly 29 percent, with slightly more in the obese category (15 percent on average).[22] The average share of children age three and older who are overweight or obese is about 31 percent for Region XI AIAN programs and 30 percent for Region XII MSHS programs.

Time Spent Managing Specific Health Issues

To further gauge the importance of specific health issues, in a supplemental question to the Health Manager Survey, we asked about the time the health manager and staff spend per week managing specific health issues, referencing 13 physical or oral health issues and eight behavioral health issues (similar to those included in Table 6.1). In estimating the time required, health managers were instructed to include "time spent providing medication at school, developing individual health care plans, including meeting with the family, staff training on the issue, communication with health care providers, paper work, monitoring, etc." Responses could be no time, if the health issue was not relevant for their programs; less than half a day a week

[22] To be consistent with our survey data analysis where the HS/EHS program is the unit of analysis, we are reporting the unweighted average across programs in the percentage of children who are overweight or obese. Thus, each program receives a weight of one regardless of program size, similar to our analysis of the Health Manager Survey data. This is not the same calculation as the percentage of children in Head Start who are overweight or obese, which may be of interest for other reasons. That indicator would require calculating the weighted average overweight or obese percentage across HS/EHS programs, where programs are weighted by the number of children in the program. We continue to report unweighted average percentages across programs in later tables in this chapter based on the PIR data.

(i.e., less than 10 percent of the time); between half a day and a full day per week (i.e., 10 to 20 percent of the time); or more than a day a week (i.e., more than 20 percent of the time).

For each health condition, Table 6.3 shows how all HS/EHS programs are distributed across the levels of time allocation, from no time to more than a day a week. This percentage distribution is calculated excluding cases of nonresponse, as well as those cases where health managers did not know the time involved (a share that ranged from 6 to 31 percent, depending on the health issue). Given the relatively higher rate of missing data for this series of time estimates and the smaller number of respondents to the supplemental questions, some caution is warranted in the interpretation of these estimates, as those who did not respond may not be a random subset of all respondents.

Nevertheless, the patterns, in large part, are consistent with the relative importance of various health conditions, as indicated in Table 6.1, where health managers identified the major health issues of concern for their programs. In particular, the physical or oral health conditions that are most often cited as requiring more than a day a week to manage include tooth decay or cavities (32 percent estimated this time requirement), asthma (21 percent), and overweight and obesity (20 percent). Proper use or administration of medication, medical equipment, or medical supports was also frequently cited as requiring more than a day a week (16 percent). The behavioral conditions most likely to be cited as requiring the highest time commitment were developmental delays (31 percent stated the time requirement was more than a day a week) and autism spectrum disorders (17 percent). For all conditions listed in Table 6.3, if any time commitment was required, the modal response was less than half a day a week.

Table 6.2. Incidence of Overweight and Obesity for Head Start Children Age Three and Older: PIR Data by Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Head Start Only	Region XII, Head Start Only
Child weight category at enrollment based on BMI (average % distribution)					
Underweight	–	4.2	–	2.6	3.1
Healthy weight	–	67.2	–	66.7	66.4
Overweight	–	13.7	–	15.5	13.3
Obese	–	15.0	–	15.2	17.2
Number of programs	–	1,762	–	142	53

SOURCE: Authors' analysis of 2012–2013 Head Start PIR data.
NOTES: Reported for children age three and older only. Underweight is defined as BMI below the fifth percentile for the child's age and sex. Healthy weight is BMI at or above the fifth percentile and below the 85th percentile. Overweight is at or above the 85th percentile and below the 95th percentile. Obese is at or above the 95th percentile. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. Complete PIR data are missing for six programs in total: four HS programs and two EHS programs (one of which is in Region XII). Data on BMI are not reported for one Head Start grantee. – = data are not available.

Table 6.3. The Time Staff Spend per Week Managing Health Issues: All Program Types

Measure	Percentage Distribution				
	None, Not an Issue in Program	Less Than Half a Day per Week	Between a Half Day and a Full Day	More Than a Day a Week	*[Missing or Don't Know]*
Physical or oral health issues					
Diabetes	58.6	32.6	5.2	3.5	*18.7*
Overweight and obesity (BMI above the 85th percentile)	6.5	46.5	27.4	19.6	*18.7*
Underweight or stunting or failure to thrive	30.4	53.6	10.8	5.2	*25.7*
Asthma or other lung disease	5.8	44.6	28.4	21.2	*14.1*
Vision conditions	20.9	53.0	19.3	6.8	*20.7*
Hearing conditions	22.6	53.2	17.9	6.2	*19.0*
Ear infections	29.9	47.9	14.8	7.4	*23.4*
Lead poisoning	49.9	40.3	5.7	4.1	*22.0*
TB	78.3	18.0	2.6	1.1	*24.4*
Anemia (e.g., sickle cell, low iron)	31.2	51.0	12.7	5.1	*20.9*
Infectious diseases (e.g., HIV)	26.4	45.8	15.0	12.7	*22.8*
Proper use or administration of medication, medical equipment, or medical supports	11.1	47.2	26.1	15.7	*15.8*
Tooth decay or cavities	4.4	32.7	31.4	31.5	*15.7*
Behavioral health issues					
Child neglect or abuse	15.3	60.3	17.6	6.9	*29.2*
Family violence	22.6	55.3	14.9	7.2	*34.3*
ADHD or ADD	19.8	47.9	19.9	12.4	*30.2*
PTSD	51.4	39.3	4.2	5.1	*43.5*
Depression	35.0	43.7	11.1	10.2	*37.2*
Anxiety (including OCD)	35.9	40.5	15.5	8.1	*39.8*
Autism spectrum disorders	19.0	41.4	22.8	16.8	*30.1*
Developmental delays (including language delays)	3.1	33.9	32.0	31.0	*21.1*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 376 health manager respondents for 483 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Additional insight on time allocation comes from the PIR, which records the average number of hours per week that the health manager spends coordinating services (results reported in Table B.7 in Appendix B). Across all HS/EHS programs in the 2012–2013 study frame, our calculations indicate that health managers spend an average of 20 hours per week in service coordination addressing the health conditions of children in their programs. Average hours are slightly higher for this purpose in HS programs (22 hours), compared with EHS programs (17 hours).

Chronic Health Conditions and IDEA Services

Children with diagnosed disabilities may be eligible for Part B or Part C services IDEA. As shown in Table 6.4, where we report on the results of a supplemental question on this topic, health managers in just under one-half of all HS/EHS programs (46 percent) reported one or more children who are not currently eligible for such services but otherwise have a chronic

health condition that the health managers feel needs additional supports. Programs with such children typically have one to five children who need additional supports (16 percent for all HS/EHS programs), but a minority of programs reported more than 20 such children (14 percent). In a follow-up supplemental question, health managers were asked to report the health conditions requiring additional supports that suggest eligibility for IDEA services. With eight conditions listed, health managers selected about three conditions on average (ranging from one to eight). The conditions receiving the highest rate of mention were undiagnosed or early indication autism (46 percent), ADHD or ADD (37 percent), and asthma or other lung disease (33 percent). These patterns are very similar for HS programs and EHS programs, with the exception that health managers in EHS programs were more likely to mention premature birth (27 percent) as a condition potentially conferring IDEA eligibility.

Table 6.4. Chronic Health Conditions for Children in HS/EHS Programs and IDEA Services: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Number of children who are not eligible for services under Part B or Part C of IDEA but have chronic health conditions that you feel need additional supports (% distribution)			
None	53.5	55.0	51.0
1 to 5	16.2	16.1	16.3
6 to 10	6.8	5.4	9.1
11 to 15	4.5	4.7	4.1
16 to 20	5.3	4.2	7.0
21 to 25	3.6	3.4	4.0
26 or more	10.1	11.0	8.5
[Missing]	*21.0*	*22.5*	*18.3*
Health condition(s) that require enough additional supports in the HS/EHS program to make health manager think that condition(s) could make a child eligible for Part B or Part C services			
Average number reported (*N*)	2.9	2.9	2.9
Percentage for each condition (%)			
Diabetes	13.3	13.7	12.6
Asthma or other lung disease	32.8	32.8	32.7
ADD/ADHD	36.8	38.6	33.4
Chronic/recurrent ear infections (otitis media)	15.3	14.9	16.1
Premature birth	19.3	15.3	26.5
Oral motor/feeding problems	20.1	18.3	23.3
Undiagnosed autism (or early indication autism)	46.2	45.4	47.7
Neurodevelopmental disorder—not otherwise specified	29.9	29.9	30.0
[Missing]	*25.6*	*27.2*	*22.7*
Number of health manager respondents	376	323	204
Number of programs	483	298	185

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Additional Perspectives from Health Mangers on Medically Fragile Children

In discussing how HS/EHS programs support medically fragile children, most health managers with whom we spoke had a very clear and consistent approach for ensuring the health and safety of these children while in their care. Health managers noted that as soon as a child with special needs is identified (typically during the application or screening process), the health manager and staff begin to plan for the child's arrival. This typically involves meeting with parents, doctors or specialists, training teachers, and other staff who will support the child and developing an individualized health plan (IHP). Modifications are made to the environment as necessary; health managers noted that most-common modifications were related to dietary restrictions for allergies or diabetes. Prior to the child's enrollment, staffing needs are also reviewed to determine whether additional staff are required to meet the needs of that child.

> *We start doing recruitment in February and March for the next year. We are pretty aware of the needs coming in for the next year. I research what is going on with the child. I make an appointment with parents/family before we start. We create individualized health plans for each child [with special health care needs]. We work closely with the pediatrician. I use some templates from [City] Children's Hospital.* —Health manager

> *We had to redo how we posted our menus, so I counted all carbs, how many in a quarter cup of mashed potatoes, and then staff had to learn what a quarter cup looked like and then teachers had to learn how to calculate what that meant for insulin pump adjustment.* —Health manager

Health Issues for Adults in HS/EHS Families

Health managers were also asked to identify the major health concerns facing the adult family members of enrolled children, with a possible list of 13 physical, mental, and behavioral health issues. As seen in Table 6.5, about six health conditions were selected on average across HS/EHS programs (ranging from one to 14). Table 6.5 also shows the percentage of programs where the health manager indicated that a given health condition or issue was a concern for the program. Again, these responses reflect health managers' perceptions about the most-salient health concerns, not necessarily those with the highest incidence.

For all HS/EHS programs, the adult health concerns that were most often mentioned by programs as a concern include overweight and obesity (82 percent of programs), smoking (68 percent), low health literacy (64 percent), alcohol (51 percent), depression (50 percent), and family violence (50 percent). While the first health issue also rises to the top of the concerns for children (see Table 6.1), health managers must contend with additional health concerns that are unique to the adult family members, ones that would be classified as mental or behavioral health issues. Interestingly, compared with HS programs, the proportion of health managers in EHS programs with a concern about parental depression is higher (58 percent versus 46 percent of

programs) and also higher when reporting concerns about low parental health literacy (68 percent versus 61 percent).

Region XI AIAN programs stand out for a relatively higher rate of concern for diabetes (74 percent of programs), alcohol (80 percent), prescription drug dependence (56 percent), and dependence on illegal substances or drugs (63 percent)—health issues that have a high prevalence in tribal communities (Office of Minority Health, 2016). For most of the health issues listed in Table 6.4 (the exceptions are diabetes, infectious diseases, alcohol, and low health literacy), the rate of concern is lower for Region XII MSHS programs than it is for HS/EHS programs overall, a pattern that may or may not signal an underlying difference in the prevalence of the health condition for the Region XII Head Start adult population.

Table 6.5. Program-Reported Health Concerns for Adult Family Members of Children in HS/EHS Programs: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Health issues facing adult family members of children in the program					
Average number reported (*N*)	5.9	5.8	6.1	7.4	5.2
Percentage of programs reporting each health condition as a major concern (%)					
Overweight and obesity	81.9	82.0	81.7	87.9	72.4
Smoking	67.5	66.8	68.7	73.2	55.1
Low health literacy	63.8	61.3	68.4	55.1	66.9
Alcohol	51.3	51.6	50.6	79.7	53.2
Depression	50.2	45.6	58.4	47.8	37.0
Family violence	49.8	47.7	53.6	62.1	44.3
Illegal substance/drug dependence	40.7	40.3	41.3	63.3	16.9
Diabetes	39.0	37.7	41.5	74.3	45.7
Asthma or other lung disease	35.1	34.5	36.2	34.8	16.9
Anxiety (including OCD)	31.3	29.3	34.9	32.5	16.4
Prescription drug dependence	24.8	24.6	25.2	55.6	9.7
PTSD	11.5	10.9	12.6	14.9	5.1
Infectious diseases (e.g., HIV, TB)	6.9	6.2	7.9	9.9	17.7
Other adult health problem	4.8	4.5	5.4	7.1	3.5
[Missing]	*5.6*	*5.2*	*6.3*	*9.9*	*4.0*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Response categories have been reordered from highest to lowest prevalence among all HS/EHS programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Some of these same adult health conditions also show differences by health manager health-related education and program size or rural-urban status (see Table H.6.5 in Appendix H). Programs where the health manager has more health-related education tend to be more likely to select asthma, anxiety, smoking, and low health literacy as major health concerns. Some conditions were more likely to be mentioned in larger programs than in smaller ones: diabetes, overweight and obesity, and asthma, while the reverse holds for prescription drug dependence. In

the case of urbanicity, some conditions were more likely to be mentioned in mostly urban programs than in mostly rural ones (e.g., depression and low health literacy), while the opposite pattern exists for other conditions, which were more likely listed as health concerns in smaller and more-rural programs (e.g., smoking, alcohol, prescription drug dependence, and illegal substance dependence). For many other conditions listed in Table 6.5, however, there is no substantial relationship to the three characteristics we examined.

Health Insurance Coverage and Health Care Access

HS/EHS programs, in their PIRs, tally the health insurance coverage status of enrolled children and the pregnant women the programs serve.[23] In addition, the reports record children's access to regular sources of medical and dental care.

Health Insurance Coverage for Children and Pregnant Women

Ensuring that enrolled children are covered by health insurance is a central objective for the Head Start health services area, so it is a key indicator tracked in the PIR, both at enrollment and at the end of the enrollment year. Any increase over time may reflect the efforts on the part of the HS/EHS program to obtain coverage, or it may reflect other factors. Table 6.6 indicates that health insurance coverage rates exceed 90 percent on average at both the start and end of the program year, with a slight increase from 94 percent to 97 percent between the two points. While coverage rates are similar for HS programs and EHS programs, the average coverage rates range from 81 to 87 percent at the start of the program year for Region XI and Region XII programs, although the average rate is 84 to 89 percent by the end of the program year.

For those with health insurance, the PIR also records the source of coverage. Given that most children served by HS/EHS programs have family incomes below the poverty level, we would expect to see Medicaid or the Children's Health Insurance Program (CHIP) as the primary source of insurance coverage, and Table 6.6 shows that that is the case. With 89 percent of children on average covered by Medicaid or SCHIP, public insurance is the dominant source, and the source of coverage changes little between the start and end of the program year. For children in Region XI AIAN programs, private coverage has a larger share (13 percent on average), while public coverage through Medicaid or SCHIP is even more prevalent (95 percent on average) for children in Region XII MSHS programs.

[23] The PIR data are for the 2012–2013 program year, prior to the full implementation of the Affordable Care Act, including the expansions of the Medicaid program. However, most Head Start children would be eligible for Medicaid if their family incomes were below the poverty level.

Table 6.6. Health Insurance Coverage for HS/EHS Children: PIR Data by Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Health insurance coverage rate (average %)					
At enrollment	94.2	93.8	94.7	86.7	80.5
At end of enrollment year	96.6	96.4	97.0	88.7	84.3
Health insurance coverage source for those with coverage (average % distribution)					
At enrollment					
Medicaid and/or SCHIP	88.9	87.6	91.1	74.1	94.6
State-only funded insurance	3.0	2.9	3.3	7.9	3.9
Private insurance	7.2	8.4	5.0	13.2	1.5
Other insurance	1.0	1.1	0.6	4.7	0.1
At end of enrollment year					
Medicaid and/or SCHIP	89.0	87.7	91.1	74.1	94.6
State-only funded insurance	3.0	2.8	3.2	8.0	3.9
Private insurance	7.2	8.3	5.1	13.2	1.4
Other insurance	0.9	1.1	0.6	4.6	0.1
Number of programs	2,746	1,750	996	198	40

SOURCE: Authors' analysis of 2012–2013 Head Start PIR data.
NOTES: Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. PIR data are missing for six programs in total: four HS programs and two EHS programs (one of which is in Region XII). In addition, Region XII programs that have both HS and EHS complete a single, combined PIR, so we are not able to separately identify health insurance coverage rates for the HS and EHS components of those programs. Thus, results are missing for 13 Region XII HS programs and 13 Region XII EHS programs.

Ensuring health insurance coverage for the pregnant women in families served by Early Head Start is also a priority and therefore tracked in the PIR for EHS programs. Table 6.7 displays parallel information on health insurance coverage for the pregnant women served by Early Head Start, and the overall patterns are very similar to those for children's coverage. On average, health insurance coverage rates for pregnant women in EHS programs are about 90 percent and increase by a few percentage points from the time of enrollment to the end of the enrollment year. Public health insurance sources dominate, primarily Medicaid (CHIP does not apply). The average insurance coverage rate is lower for Region XII MSHS programs. The share of coverage from Medicaid is lower for pregnant women in Region XI AIAN programs, but the share of private insurance is higher.

Table 6.7. Health Insurance Coverage for Pregnant Women in EHS Programs: PIR Data by Program Type

Measure	All Regions, Early Head Start Only	Region XI, Early Head Start Only	Region XII, Early Head Start Only
Health insurance coverage rate (average %)			
At enrollment	88.9	89.4	68.6
At end of enrollment year	91.8	89.9	76.4
Health insurance coverage source for those with coverage (average % distribution)			
At enrollment			
Medicaid and/or SCHIP	86.2	67.8	97.3
State-only funded insurance	4.8	9.6	1.4
Private insurance	7.7	20.0	0.9
Other insurance	1.3	2.6	0.4
At end of enrollment year			
Medicaid and/or SCHIP	86.6	69.0	97.7
State-only funded insurance	4.8	9.8	1.3
Private insurance	7.3	18.7	0.7
Other insurance	1.2	2.6	0.3
Number of programs	892	44	10

SOURCE: Authors' analysis of 2012–2013 Head Start PIR data.
NOTES: Reported for EHS programs only. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. All PIR data are missing for six programs in total: four HS programs and two EHS programs (one of which is in Region XII). Data on health insurance coverage for pregnant women are not reported for 117 EHS programs (12 of which are Region XI programs and three of which are Region XII programs) because they reported serving no pregnant women. – = data are not available.

Access to Medical and Dental Homes for Children

The PIR provides information for children in HS/EHS programs regarding their access to a medical home ("an ongoing source of continuous, accessible health care") and a dental home ("continuous, accessible dental care provided by a dentist"). As with health insurance, access is recorded at enrollment and at the end of the enrollment year. As seen in Table 6.8, access to a medical home is reported in the PIR to be nearly universal: on average, 94 percent at enrollment and 97 percent by the end of the year, with coverage rates that are very similar for HS programs and EHS programs and for Region XI and Region XII programs.

Compared with medical home access, access to a dental home, also shown in Table 6.8, is reported in the PIR data to be lower at enrollment: about 76 percent on average for HS/EHS programs combined. This overall average masks a considerably lower share, 64 percent on average, for participants in EHS programs at enrollment. Coverage rates are higher by the end of the enrollment year—about 87 percent for HS/EHS programs combined—but still below the access rate for a medical home. At the end of the enrollment year, children in EHS programs are still less likely to have access to a dental home than their counterparts in HS programs (77 percent versus 93 percent).

Table 6.8. Medical Home Status of Children in HS/EHS Programs: PIR Data by Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Children with an ongoing source of continuous, accessible health care (average %)					
At enrollment	93.9	93.9	94.0	92.4	92.1
At end of enrollment year	96.9	96.8	97.0	93.8	94.9
Children with continuous, accessible dental care provided by a dentist (average %)					
At enrollment	75.9	82.4	64.4	82.2	76.0
At end of enrollment year	87.0	92.9	76.7	88.2	86.2
Children receiving services through the IHS (average %)					
At enrollment	5.2	5.9	4.0	65.7	0.0
At end of enrollment year	5.3	6.0	4.0	66.1	0.0
Children receiving services through a migrant community health center (average %)					
At enrollment	0.5	0.7	0.1	0.1	25.8
At end of enrollment year	0.7	0.9	0.3	0.1	31.4
Number of programs	2,746	1,750	996	198	40

SOURCE: Authors' analysis of 2012–2013 Head Start PIR data.
NOTES: Percentages are computed for nonmissing cases. PIR data are missing for six programs in total: four HS programs and two EHS programs (one of which is in Region XII). In addition, Region XII programs that have both an HS program and an EHS program complete a single, combined PIR, so we are not able to separately identify the measures in this table for the Head Start and Early Head Start components of those programs. Thus, results are missing for 13 Region XII HS programs and 13 Region XII EHS programs.

The PIR also records the number of children at enrollment and at the end of the enrollment year receiving services through IHS and receiving health services through a migrant community health center. Although these two types of services are most relevant for Region XI AIAN programs and Region XII MSHS programs, respectively, Table 6.8 shows coverage rates for HS/EHS programs overall, separately for HS programs and EHS programs, and separately for the Region XI and Region XII programs. When viewed across HS/EHS programs combined or separately, the average percentage of children with access to these sources of care is small, no more than 2 percent. However, for Region XI AIAN programs, IHS is a source of care for 66 percent of children at enrollment and at the end of the enrollment year. For Region XII MSHS programs, 26 percent of children at enrollment and 31 percent of children at the end of the year are served by a migrant community health center.

Summary of Chapter Findings

The Health Manager Survey data highlight health managers' assessments of the multiple health issues that pertain to HS/EHS children and their families. Importantly, the key child and adult health issues span physical health, behavioral and mental health, and oral health. This means that

health managers must address important health concerns on three fronts. Most children in HS/EHS programs are covered by some form of health insurance, but, as we will see in later chapters, HS/EHS programs must support children's health through screening and referral, support for treatment, and ongoing health and developmental supports.

Most of these patterns of health conditions and health insurance coverage are largely the same for HS programs and EHS programs, although there are some differences, mostly attributable to the population of children and families the programs serve. For example, compared with HS programs, health managers in EHS programs were more likely to cite ear infections as a major health concern for children and parental depression as a major health concern for adults.

Where we could examine differences for Region XI AIAN programs, we see a higher rate of concern for child and adult health issues more prevalent in tribal communities (e.g., ear infections, diabetes, child abuse and neglect, alcohol, drug dependence). In Region XII MSHS programs, there is relatively more concern associated with several physical health issues (overweight and obesity and oral health), but relatively fewer mentions of concern regarding several behavioral health issues (child abuse and neglect, ADHD and ADD, and autism). PIR data also show, as would be expected, that a higher share of children in Region XI, compared with HS/EHS programs overall, are receiving health services through IHS. Likewise, in Region XII, there is a higher incidence of participation in a migrant community health center.

There are also some differences in how health managers rate the importance of specific health concerns for children and adults based on the health manager's background, program size, and program rural-urban status. These patterns likely reflect some combination of differing incidence in these conditions based on program circumstances, as well as differential perceptions on the part of the health managers in the import attached to these concerns.

7. Health Management of the Individual Child

Broadly speaking, one goal of the health services area of Head Start is to assist with the management of the health of each individual child, and many of the health manager tasks discussed in Chapter Four (e.g., maintaining health records) pertain to this objective. Central to this goal is obtaining and tracking child health information. Another critical element is communication—between HS/EHS staff and the child's parent or guardian and among the numerous HS/EHS staff members who work with the child to meet their unique health needs. It is important to note that while these tracking and communication activities may occur more often for children with special health care needs, they are relevant for all children in HS/EHS programs. This chapter focuses on these issues and presents results based on the Health Manager Survey (module 2).

Chapter Seven Methods

- HS/EHS programs are the unit of analysis.
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (module 2) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups, defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.
- Insights from the interviews with health managers and other staff and open-ended survey responses are integrated where relevant.

We first discuss the results of several survey questions that inquired about how HS/EHS programs obtain and track information about individual child health. We then discuss approaches to communication with parents and the associated challenges. A final section covers findings with respect to approaches to communication of child health needs with staff. In each case, we view our findings as descriptive and not relevant for determining whether HS/EHS programs are complying with specific health-related requirements.

Key findings from these analyses include the following:

- Virtually all HS/EHS programs track child health information in a formal system, and about 90 percent do so through an electronic system. Health information is gathered from a variety of sources, most commonly from written records from health providers, immunization records, and histories obtained from parents or guardians (either orally or in writing). Health records are typically updated when changes occur, although some programs also make routine annual or biannual updates.
- While maintaining health records may be a routine process, health managers reported in interviews that it is time-consuming, both because of the volume of information involved and the time required to obtain the information from various sources. Health managers

mentioned the lack of administrative support staff to assist with this activity and how it can crowd out time to focus on more-substantive aspects of their jobs. This issue was even more salient for health managers in EHS programs because of the more-frequent well-child visits for infants and toddlers, which require continual record updating.

- Communication with parents about their children's health is also a routine function, with the typical program communicating once or twice a month. Again, health managers rely on multiple approaches, typically in writing or orally when children are dropped off or picked up. At the time of the survey, few programs relied on email for routine communication. Routine parental communications is also common for children with special needs. For the most part, programs reported communicating in the parents' preferred language.
- When reporting on challenges in communicating with parents about their children's health needs, the most-prevalent responses centered on parents' openness to discussing health issues, lack of understanding of the importance of health issues, and frequent phone number changes. These challenges spill over to other program staff, who are asked by the health manger to assist with parental communications.
- Communication among program staff about the health needs of children is also part of the staff routine, with the use of both formal and informal mechanisms, from meetings, to email, to the sharing of child health records.

Where possible, we also examined differences in survey results for programs in Region XI and Region XII, as well as by health manager and program characteristics. Any important differences identified are discussed in the concluding section of the chapter.

Obtaining and Tracking Child Health Information

Three survey questions asked health managers about their approaches for gathering and monitoring individual child health information. We begin with a discussion of those findings before turning to additional insights from the health manager interviews.

Health Manager Survey Responses

Table 7.1 first shows the percentage of HS/EHS programs overall, and separately by type, that use a formal system to track health information, either an electronic system or a paper and file system. Overall, formal systems are in place in virtually every program, and the dominant approach is an electronic system, used by 89 percent of programs. This share is similar for HS programs and EHS programs. Region XI AIAN programs are somewhat more likely to rely on paper-based systems (26 percent), while Region XII MSHS programs are almost universally employing electronic systems (94 percent). In terms of other program characteristics (see Table H.7.1 in Appendix H), there is no difference in the use of a tracking system or the type of tracking system by health manager health-related background. Larger programs are somewhat more likely to use an electronic system than smaller programs (90 percent versus 84 percent), and the same is true for mostly urban programs compared with mostly rural ones (90 percent versus 83 percent).

Table 7.1. Approach for Obtaining and Tracking Child Health Information: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Does program have a process for getting and tracking health information for each child? (% distribution)					
No	0.1	0.1	0.3	0.0	0.0
Yes, use electronic tracking system	88.5	87.0	91.3	74.2	94.1
Yes, use paper/file system	11.3	12.9	8.4	25.8	5.9
[Missing]	*6.2*	*5.7*	*7.1*	*12.5*	*6.8*
Source for child health information input into health record					
Average number of sources reported (*N*)	5.1	5.2	4.9	5.5	5.1
Percentage for each source (%)					
Written record from health provider	98.5	98.4	98.9	100.0	100.0
Interview/oral history from parent/guardian	85.6	86.5	84.0	78.6	71.6
Written history from parent/guardian	75.3	78.0	70.3	88.4	64.0
Immunization record	96.8	96.9	96.8	98.5	95.8
Written record from teacher	43.7	46.7	38.3	50.8	41.3
Written note from home visits	55.7	56.3	54.7	61.4	44.2
Child health file from previous child care program	47.4	50.9	41.3	50.3	79.1
Other	7.3	7.1	7.5	16.8	10.9
[Missing]	*5.8*	*5.4*	*6.4*	*11.1*	*6.4*
How often are child health records updated? (%)					
Once a year	16.0	16.0	16.1	11.9	8.6
Twice a year	4.4	4.9	3.7	7.3	4.0
More than twice a year	22.7	21.4	25.1	25.0	34.7
If/when changes to the child's health occur	87.2	88.4	85.1	86.4	84.4
Don't update the health record	0.2	0.2	0.4	0.0	0.0
[Missing]	*5.8*	*5.4*	*6.6*	*11.1*	*6.4*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Health managers were asked to indicate the various sources of information for health records, with the option of selecting multiple sources from the seven sources listed. Indeed, as displayed in Table 7.1, HS/EHS programs gather information from an array of sources, with an average of about five sources selected (ranging from one to eight, including the residual "other" category), consistent with findings presented in Chapter Four about the challenges of record keeping. Most common are written records from health providers (99 percent), followed by immunization records (97 percent), interviews or oral histories from parents or guardians (86 percent), and written histories from parents or guardians (75 percent). Other sources used by closer to one-half of all HS/EHS programs include written notes from home visits, child health files from a prior

child care program, and written records from teachers. The relative importance of the various sources is similar for HS programs and EHS programs. Region XI AIAN programs tend to rely somewhat more on written histories from parent or guardians and less on oral histories. At the same time, the tabulations suggest that Region XII MSHS programs appear to have a higher reliance on records from a prior child care program relative to information gathered orally or in writing from parents, a pattern that is likely a reflection of the higher rates of mobility among the population of children and families served.

There are some differences in these patterns based on other program characteristics (see Table H.7.1 in Appendix H). Compared with health managers with health-related bachelor's degrees, health managers with no health-related education background are more likely to rely on a written history from parents (81 percent versus 72 percent) and on written records from teachers (48 percent versus 42 percent). These same two methods are more prevalent for larger programs than for smaller ones and more prevalent in mostly rural programs than in mostly urban ones. The use of written notes from home visits and child health files from previous providers also show the same pattern. At the same time, obtaining written records from health providers is a method used almost universally regardless of program characteristics.

The survey also asked health managers to indicate how often child health records are updated, again allowing for the possibility that routine and nonroutine updates may be made. As seen in Table 7.1, the most common response was that updates are made if or when changes to the child's health occur (87 percent). Updates that occurred more than twice a year were reported by 23 percent of programs, and another 16 percent reported making an annual update. This pattern is quite similar across the program types, with the exception of Region XII MSHS programs, where more-frequent updates are made. There are no clear patterns in the frequency with which records are updated based on health manager health-related background, program size, and program rural-urban status (see Table H.7.1 in Appendix H).

Additional Perspectives from Health Manager Interviews

The process of obtaining and tracking health information was a topic that was frequently raised by health managers during our interviews as one of the most time-consuming tasks. In addition to the sheer volume of data to be entered annually or biannually into the program's tracking system, substantial amounts of time are spent tracking down and obtaining relevant health information from families and providers (this is discussed more in Chapter Eight). Many health managers reported that because of the time it takes to keep up with the paperwork, they have less time to focus on tasks that would improve the health of children and families. This results in a feeling that the health services area is falling short or not living up to its potential, which is having carryover effects on job satisfaction. Health managers for EHS programs noted that this is particularly difficult, as the younger children must see the provider more frequently for well-child visits, which requires more-frequent data entry and presents more opportunities for a child to fall behind, requiring additional follow-up from health managers.

Because of the strict regulations, I need to follow for both HS/EHS and local and state regulations for recordkeeping and monitoring, I spend too much of my time making sure I follow the rules and not enough time individually making a difference in the population I serve. I feel I do not have enough time to spend on education, which is what will ultimately make the difference in the fight against poverty and the health disparities so evident in the urban black and Latino communities. I do enough to cover the bases but never really am able to advocate strongly in any one area without another area suffering. I am frustrated and feel the health program isn't able to be used to its fullest potential. —Health manager

The paperwork and responsibility of health coordinators/managers can be overwhelming. —Health manager

Increased documentation requirements are making it more difficult to find time to relate to families and develop relationships. It seems we spend more time documenting what we do than we spend actually doing it. —Health manager

Communicating with Parents and Guardians

A series of questions in the online survey ascertained the frequency and nature of communications between HS/EHS programs and children's parents or guardians about the children's health and developmental status. We begin with those survey response and then detail additional insights from the health manager interviews.

Health Manager Survey Responses

Table 7.2 first reports on the frequency of communications between HS/EHS programs and families. Overall, the modal response was communications regarding the child's health and developmental status every month (23 percent of programs) or several times a month (24 percent of programs). Of the remaining programs, a similar share communicates less frequently (e.g., one to six times a year) or more frequently (e.g., weekly). For the most part, these communication patterns are very similar across program type and for Region XI AIAN and Region XII MSHS programs. The patterns were also largely similar based on other program characteristics (see Table H.7.2 in Appendix H), although there was some tendency to be more likely to report weekly communication for programs where the health manager has more health-related education and for smaller programs.

Health managers were next asked to select the most common method they use to share information about children's health with their parents or guardians, and programs rely on several methods. As seen in Table 7.2, the most common method is written communication (31 percent), followed by in-person communication at drop-off or pick-up (29 percent) and phone calls (23

percent). Email or electronic communications were reported to be rarely used (less than 1 percent), and formal meetings are also less likely to be used (6 percent). Region XI AIAN programs are somewhat more likely to rely on written communications, while Region XII MSHS programs are more likely to use formal meetings or phone calls. There are no relevant differences in these communication mechanisms based on program health manager health-related education background, program size, or program rural-urban status (see Table H.7.2).

Table 7.2 also shows the frequency with which health managers reported meeting with parents or guardians of children with special health care needs. Responses are clustered in three categories, from every two to five months (21 percent), to every month (22 percent), to several times a month (19 percent), a pattern that is very similar regardless of program type, including Region XI and Region XII programs. There are also no substantial differences in this indicator based on the other program characteristics we examined (see Table H.7.2 in Appendix H).

As a supplemental question, health managers were asked whether they create individual family partnership agreements (IFPAs) with families in their programs that are specific to reaching health-related goals. Overall, as seen in Table 7.2, health managers in 73 percent of HS/EHS programs stated that they create such health-specific IFPAs. Use of IFPAs is slightly higher in EHS programs (77 percent) than in HS programs (72 percent).

Table 7.2. Approach to Communication with Parents About Child Health: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Frequency of communication with parents/guardians about child's health and developmental status (% distribution)					
Once a year	1.6	1.5	1.8	4.3	0.0
Twice a year	5.9	6.4	4.9	2.9	11.1
Every two to five months	16.1	16.4	15.6	20.4	5.4
Every month	23.0	23.6	21.8	20.4	21.1
Several times a month	23.8	23.6	24.0	21.4	23.1
Weekly	16.5	14.4	20.3	15.7	19.9
Other	13.2	14.1	11.7	15.0	19.4
[Missing]	*5.6*	*5.3*	*6.0*	*9.9*	*4.0*
Most common method used to share information with parents/guardians about child's health (% distribution)					
Formal meetings	6.0	5.8	6.3	4.4	12.8
Phone calls	23.0	25.6	18.2	12.6	28.9
Email/electronic communication	0.3	0.5	0.2	0.0	0.0
Written communication	31.0	31.8	29.6	38.7	15.9
In-person communication at drop-off or pick-up	28.7	27.8	30.4	32.0	30.7
Other	11.0	8.6	15.3	12.2	11.7
[Missing]	*5.5*	*5.2*	*6.0*	*9.9*	*4.0*

Table 7.2. Approach to Communication with Parents About Child Health: By Program Type, *Continued*

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Frequency of meeting with parents/guardians (phone or in person) to discuss health management of a child with special health care needs[a] (% distribution)					
Never	1.2	1.2	1.2	0.0	0.0
Once a year	5.1	5.3	4.6	5.1	3.0
Twice a year	11.1	11.1	11.0	11.7	5.9
Every two to five months	20.7	20.3	21.4	24.9	20.3
Every month	22.1	22.2	21.9	20.9	22.5
Several times a month	19.4	20.3	17.8	15.6	29.9
Other	20.4	19.5	22.1	21.8	18.4
[Missing]	*6.0*	*5.8*	*6.3*	*9.9*	*6.4*
Program creates IFPAs with families specific to reaching health goals[b] (% distribution)					
No	17.0	18.9	13.4	–	–
Yes	73.4	71.7	76.5	–	–
Don't know	9.6	9.3	10.1	–	–
[Missing]	*6.9*	*6.0*	*8.4*	–	–
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference. IFPA = individual family partnership agreement.
[a] Excludes five health managers responding for five programs that reported that they do not serve children with special health care needs.
[b] Based on 376 health manager respondents for 483 programs in Supplement B. Results not reported for Region XI or Region XII programs.

Health mangers were asked to indicate how often they communicate with parents in their preferred languages and whether the communication occurred with an interpreter. The results for this supplemental question across all HS/EHS programs are shown in Table 7.3. The results indicate that communication is almost universally in English when English is the preferred language of the parent or guardian (93 percent). About one-half of all HS/EHS programs always communicate in another language that is the parent or guardian's primary or preferred language (e.g., Spanish), but 13 percent reported that this is never done. Communication through an interpreter is quite common, with 40 percent saying that they always do so if that is required. Finally, when English is not the primary or preferred language, about 46 percent stated that they do not communicate in English (i.e., they use the preferred language) and another 40 percent only sometimes communicate in English where English is not the primary or preferred language.

Table 7.3. Language Used to Communicate with Parents/Guardians: All Program Types

Language Used	Percentage Distribution				*[Missing, Don't Know, or Not Applicable]*
	Never	Sometimes	Frequently	Always	
Communicate in English, and English is the parent or guardian's primary or preferred language	0.6	0.9	5.9	92.7	*8.4*
Communicate in another language that is the parent or guardian's primary or preferred language (e.g., in Spanish if parent/guardian is Spanish-speaking)	13.3	14.0	20.8	51.9	*14.5*
Communicate through an interpreter, to the extent feasible	10.7	30.1	19.6	39.6	*21.3*
Communicate in English, but English is not the primary or preferred language	45.9	39.7	9.2	5.2	*28.0*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 376 health manager respondents for 483 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing, don't know, or not applicable and might not sum to 100 because of rounding. The percentages of cases for the missing, don't know, or not applicable categories are shown for reference.

A final supplemental question asked about the factors that make it challenging to communicate with parents and guardians about their children's health needs. The results of this question are tabulated in Table 7.4, for all HS/EHS programs and separately for HS programs and EHS programs. Thirteen issues were included in the questionnaire, and, on average, health managers selected close to five issues (with a range from one to 13). Across all HS/EHS programs, two responses were most often chosen: the "parent or guardian resists or does not understand importance of screening or treatment" (65 percent) and "families change their cell or telephone numbers a lot" (64 percent). The next most prominent issue was "parent or guardian resistance or reluctance to speak with staff about health issues" (46 percent). Other issues selected by about one in three programs include high residential mobility so that addresses are not current, literacy barriers, parents who are not at drop-off and pick-up, and parents and guardians who do not have time. These same issues rise to the top of the list for both HS programs and EHS programs.

Table 7.4. Factors That Make It Difficult to Communicate with Parents/Guardians About Child Health Needs: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Factors that make it most difficult to communicate with parents or guardians about the health of their children			
Average number reported (*N*)	4.6	4.6	4.7
Percentage for each factor (%)			
Cultural or religious beliefs or barriers	12.7	10.9	16.0
Language barriers between HS/EHS staff and families	21.3	22.4	19.4
Not having health-related materials in the appropriate language	13.9	13.1	15.3
Literacy barriers (reading ability or health literacy level of parent or guardian is low)	30.2	29.7	30.9
Not having health-related materials at an appropriate literacy or reading level	16.5	14.7	19.8
Families move a lot/mailing addresses are not current	32.2	30.6	35.0
Families change their cell or telephone numbers a lot	64.3	66.0	61.4
Parent/guardian does not have a telephone	27.3	28.3	25.5
Parent/guardian resistance or reluctance to speak with staff about health issues	46.2	46.5	45.7
Parent/guardian does not drop off/pick up (e.g., rides bus), which limits how much I see or talk to families	39.0	41.6	34.3
Parent/guardian does not have time	36.0	36.3	35.5
Parent/guardian resists or does not understand importance of screening/treatment	64.7	65.5	63.3
Lack of staff time to follow up	21.0	21.2	20.5
Other	4.5	4.1	5.2
[Missing]	*7.4*	*6.3*	*9.4*
Number of health manager respondents	376	323	204
Number of programs	483	298	185

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Additional Perspectives from Staff Interviews on Communication

Most staff reported during our interviews that they are often asked by the health manager to reach out to parents to discuss the need for a screening or medical appointment for their children who are not up-to-date, for example. The rationale for this is that staff have more-regular interactions with parents and may have a more trusted relationship with the family, whereas the health manager is typically overseeing multiple program locations and does not have as much of a relationship with families. Staff reported that a significant amount of their time is spent trying to reach and engage parents to address the health needs of their children. While some noted that they have received limited training on how to work with families around health issues, they continue to struggle with how to engage families efficiently and effectively, given the sensitive nature of these issues. These finding suggest that supports and training on this topic may be useful not only for health managers but also for staff.

> *The truth of the matter is that we work with parents. They have no reason to trust us, they can be hostile, they have mental health issues and concerns, and we are*

dealing with parents that are coming from places that are different. So we need training that would help staff learn new ways to connect with families, to ask questions, to get services to parents and children without making parents feel defensive or like they are lacking in some way. We get good training on child development, and we are well educated, but working with adults in the real world and learning how to address that would be empowering for home visitors and the rest of the staff. —Home visitor

It is sometimes hard to get parents to communicate with us. Last month, none of our [EHS] children were up-to-date with medical needs. The health staff look to us, as teachers, to make sure this happens. Is there something more I could be doing or saying to help parents to understand? Parents just put it off. We are the ones that are expected to have relationship with families, but we haven't been trained on how to talk with families about health issues or given better strategies to convey these messages. Parents get information but don't take it as seriously from me. I'm the teacher, not a [health] provider. —Teacher

Communicating with Staff

Health managers were also asked about methods used within the program to communicate among program staff about the health needs of specific children. Tabulations for this supplemental question are shown in Table 7.5, for all HS/EHS programs and separately for HS programs and EHS programs. It is evident that programs rely on a variety of methods. The modal response was formal meetings (29 percent), but almost as many rely on email (22 percent) and the child's health record (18 percent), which is accessible to staff. The relative importance of these different modes is very similar across HS programs and EHS programs.

Table 7.5. Methods Used to Share Information with Staff About Child Health Needs: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Most common method used to share information among program staff about the health of specific children (% distribution)			
Formal meetings	28.8	27.5	31.2
Phone calls	11.0	12.3	8.8
Email/electronic communication	21.9	22.8	20.4
Written communication to staff	7.8	7.5	8.4
Entered in staff-accessible child health record or file	18.0	18.0	18.0
Other	12.4	12.0	13.3
[Missing]	*6.0*	*5.6*	*6.7*
Number of health manager respondents	376	323	204
Number of programs	483	298	185

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentage of missing cases is shown for reference.

Summary of Chapter Findings

The survey responses and interviews confirm that two key elements of health management of the individual child revolve around documenting child health information and communicating with a parent or guardian about the child's health. In both areas, most HS/EHS programs make a significant investment of time. Routine processes appear to be in place for most programs to obtain and document child health information, but the process can still be time-consuming and often falls to the health manager. Programs also typically have in place mechanisms for regular communication with parents and for communication among the staff. Health managers and other program staff do encounter a number of challenges in communicating with parents, an area where training and technical support may be beneficial.

Survey responses regarding the health management of the child were similar, for the most part, for HS programs and EHS programs. For those questions in the core survey, we documented a few process differences for Region XI and Region XII programs that likely reflect the available resources (e.g., an electronic tracking system) and the characteristics of the children and families served. For example, Region XI programs stand out for being more reliant on paper and file systems than on electronic ones to track child health information. Region XII programs are more likely to obtain health records from a prior child care program.

There were also some differences based on other program characteristics, with larger programs and those in more-urban areas more likely to use electronic tracking systems. Although some sources for child health information are used almost universally regardless of program characteristics (e.g., written records from providers), other sources tended to vary with program size or urbanicity. At the same time, there were no evident differences in the frequency with which records were updated, based on the three program characteristics we examined. In terms of parent communication, there were few relevant differences by the program characteristics we examined.

8. Overview of Health Services in Head Start

This chapter relies primarily on responses to the Health Manager Survey (modules 3 and 4) to provide an overview of the health services facilitated by Head Start. These services include health screenings; physical, behavioral, and mental, and oral health services provided on-site (or sometimes off-site); home-based health services; other health-related services provided for families; and health services provided for pregnant women. We also discuss how HS/EHS programs ensure that there is follow-up for the results of health screenings and other health care that children require. In subsequent chapters, we provide more detail on the coordination of and barriers to physical health, behavioral and mental health, and oral health services with providers in the community (Chapters Nine, Ten, and Eleven, respectively), as well as activities related to prevention and health promotion (Chapter Twelve). As with prior chapters and those that follow, we report on survey and interview questions that were not designed to verify whether programs were meeting specific performance standards.

Chapter Eight Methods

- HS/EHS programs are the unit of analysis
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (modules 3 and 4) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups, defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.
- Insights from the interviews with health managers and other staff and open-ended survey responses are integrated where relevant.

We begin first with health-screening services and then continue with health services provided on-site, home-based health services, and other health-related services, including those provided for pregnant women. We call attention to the following key findings with respect to *health screenings*:

- As reported by health managers, socioemotional development screening, cognitive development screening, hearing and vision screening, behavioral or mental health screening, and height and weight measurement are performed by nearly all HS/EHS programs (95 percent or more), usually on-site. (Off-site screenings are sometimes done when specific equipment is required.) Oral health screenings are offered by about 80 percent of programs. Other nonrequired screenings for less prevalent health conditions (e.g., TB, sickle cell anemia) are not as common.
- Health managers reported using a variety of strategies to ensure that screenings are performed, such as a health file review and following up with the provider or parent.

- Programs also use a variety of methods to ensure that parents or guardians complete any follow-up evaluations that are indicated by the screenings. The most-common approaches are giving parents information about the follow-up, helping with insurance coverage, helping to schedule the follow-up evaluation, and providing evaluations on-site, among other supports. It is also not unusual for programs to provide transportation to the evaluation appointment or a staff member to accompany the family. Programs then use a similar set of methods as those used for follow-up of screenings to verify that follow-up evaluations occur.
- During interviews, health managers mentioned that their staff were not always trained to perform the full range of health screenings, particularly those required for behavioral or mental health and oral health. One program reported relying on students and staff of a neighboring university for performing screenings. Other interviewees noted that mental health providers were in short supply, so long waits might be required to have a provider come to the site when that was the preferred mode of delivery. Others found providers reluctant to come to the program to perform screenings.

Regarding *health services and follow-up*, we note the following findings:

- The most common services delivered by providers on-site by a majority of programs include speech therapy, behavioral or mental health care, care or therapy for children living with disabilities, and oral disease prevention (e.g., fluoride treatment). Again, multiple strategies are used to ensure that parents follow up with any needed services.
- When interviewed, health managers and staff highlighted their roles in linking children to needed health services. Data systems and routine staff communication are used to ensure that connections with providers are made and that services are obtained. However, parent communication and follow-through were often a challenge. This often necessitated other actions to ensure participation, such as accompanying parents to appointments or assisting with translation services. Collaborations between programs and community-based providers further helped ensure participation. Issues with provider shortages were mentioned in some circumstances.
- A minority of programs offer home-based health services (40 percent). As might be expected, such services are more common in EHS programs (59 percent) compared with HS programs (33 percent). Common services include teaching parents and children about healthy behaviors, nutritional services, and health screenings. Health managers identified a number of barriers to providing services in the home, most prominently those tied to parent availability, understanding of health issues, and acceptance of services.
- Programs offer other health-related services, including the following offered by a majority of programs: information about health insurance and assistance enrolling, workshops on education and parenting, health-related events for the entire family, health and social services offered in collaboration with service agencies (e.g., hospitals), and health literacy services.
- Services for pregnant women are offered almost universally in EHS programs. An extensive set of services includes providing relevant information (e.g., nutrition, breast-feeding, child development), referrals to health care providers, and help with finding baby care items.

Any differences in these key findings for programs in Region XI or Region XII, as well as differences by health manager and program characteristics, are summarized as part of the concluding section of the chapter.

Health Screening and Follow-Up

Several survey questions pertained to health screenings and the approach to ensuring follow-up, where relevant. We focus on the health manager responses to these questions and then discuss additional insights gleaned from the semistructured interviews.

Health Manager Survey Responses

Health managers were asked to indicate, in a supplemental question, the specific health screenings offered, without charge, to HS/EHS children, selecting from a list of 14 health-related screenings or testing, including those that are explicitly mentioned in the Head Start performance standards (e.g., developmental, hearing, and vision), as well as others that are not explicitly required (e.g., oral heath screening). For those offering free screenings of a given type, health managers indicated whether the screening was provided on-site, off-site, or both. Table 8.1 shows the percentage distribution of responses for all HS/EHS programs, excluding those cases with missing data or where the health manager did not know the answer.[24]

Overall, the most common free screenings, offered nearly universally (95 percent or more of programs), were socioemotional development screening, cognitive development screening, hearing testing, vision testing, behavioral or mental health screening, and height and weight measurement. Oral health screenings are offered by about 80 percent of programs and blood pressure screening by just under 60 percent of programs. About half of all HS/EHS programs offer lead screening (52 percent), lead testing (48 percent), and hemoglobin/hematocrit testing (47 percent). The remaining types of free screening are less common, being offered by fewer than one in four programs, although these screenings are for less common conditions. These include testing for TB (22 percent), urinalysis (15 percent), and testing for sickle cell anemia (14 percent).

For the group of free screenings that are offered nearly universally, programs almost always provide the screenings on-site (although off-site may be an option too); fewer than 4 percent of the programs exclusively provide screenings for social-emotional development, cognitive development, hearing, vision, and behavioral or mental health, as well as height and weight measurement, off-site. On-site screening is also the dominant option when offered for blood pressure, oral health, and lead. By contrast, the free screening that is offered by a minority of

[24] The share of health managers who responded "don't know" was typically fewer then 0.5 percent of respondents but was just under 3 percent for sickle cell anemia testing and urinalysis.

programs for lead, hemoglobin/hematocrit, TB, urinalysis, and sickle cell anemia are more likely to be offered exclusively off-site, although some programs offer on-site testing as well.

Table 8.1. Provision of Free Health Screenings to Children in the Program: All Program Types

	Percentage Distribution				
Screening Type	**Do Not Provide**	**Provide On-Site**	**Provide Off-Site**	**Provide Both On-Site and Off-Site**	***[Missing or Don't Know]***
Social-emotional development screening	1.1	81.6	3.0	14.3	*7.2*
Cognitive development screening	2.0	80.7	3.1	14.2	*7.5*
Hearing testing	3.4	80.2	2.6	13.8	*6.0*
Vision testing	4.2	78.4	3.3	14.1	*6.4*
Behavioral or mental health screening	5.0	73.4	3.9	17.7	*7.0*
Height and weight measurement (including head circumference, if applicable)	5.2	80.0	2.5	12.3	*6.2*
Oral health screening	20.5	46.6	12.4	20.5	*6.6*
Blood pressure	41.5	43.3	7.0	8.2	*7.4*
Lead screening	48.2	24.6	18.5	8.8	*8.1*
Lead testing	52.2	17.3	21.8	8.7	*7.3*
Hemoglobin/hematocrit testing	52.8	18.6	20.2	8.4	*7.3*
TB testing	78.3	3.8	15.7	2.2	*8.6*
Urinalysis	84.5	1.4	12.1	2.0	*10.4*
Sickle cell anemia testing	85.6	1.2	12.5	0.6	*10.3*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: The list of screenings has been reordered from most to least prevalent (from smallest to largest in the "do not provide" response). Based on 359 health manager respondents for 470 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases for the missing or "don't know" categories and might not sum to 100 because of rounding. The percentages of cases that are missing or unknown are shown for reference.

Ensuring that children receive the necessary screenings is an important concern, so health managers were asked in a supplemental question to indicate, from a list of six processes, which ones were used in their programs to ensure that screenings were conducted. Table 8.2 shows the percentage of health managers who responded that they used each of the strategies, where health managers were allowed to select all that applied. Results are shown for all HS/EHS programs and separately for HS programs and EHS programs. Overall, health managers reported an average of just over four strategies in use (with a range from one to seven, including "other"). With the exception of the last strategy—using an external evaluator to review health records—a majority of health managers reported using each strategy in their programs. Most common was conducting a periodic review of the child health files (92 percent), followed closely by checking with health care providers to obtain a copy of the health service record (85 percent) and checking with parents or guardians to ensure that screenings were completed (85 percent). Somewhat fewer programs follow up with classroom teachers (64 percent) or with health staff at regular program meetings (63 percent) to ensure that children receive screenings. An external evaluator is used in just 15 percent of programs. For the most part, the share of programs using the various processes was similar for HS programs and EHS programs.

Table 8.2. Processes Used to Ensure Child Receives Necessary Screenings: By Program Type

Process	All Regions, Total	All Regions, Head Start Only	All Regions, EHS Only
Processes used to ensure that children receive necessary screenings			
Average number reported (*N*)	4.3	4.3	4.3
Percentage for each process (%)			
Conducting a periodic review of child health files to ensure that screenings were received	92.3	91.8	93.1
Following up with health care providers to obtain copy of health service record	85.0	84.1	86.5
Following up with parents/guardians to ensure that screenings were completed	85.1	83.9	87.1
Discussing with health staff at regular program meetings	63.3	62.7	64.3
Following up with classroom teachers	63.8	66.9	58.4
Using an external evaluator to review health records	15.0	16.9	11.7
[Missing]	*2.9*	*3.2*	*2.3*
Number of health manager respondents	359	305	186
Number of programs	470	292	178

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Another important issue is ensuring that parents or guardians complete follow-up evaluations that are indicated by screenings for specific conditions. In a supplemental question, health managers were asked to report how often they employ various supports to encourage parents or guardians to attend follow-up evaluations. The responses for each of the nine types of support are shown in Table 8.3 for all HS/EHS programs, with the percentage distribution shown across the five response categories: never, rarely, sometimes, often, and always. The percentage distributions are calculated excluding those cases that were missing or where the health manager responded "don't know" or "not applicable."[25] As with screenings, the responses indicate that health managers are using a variety of strategies to support parents in completing follow-up evaluations. The strategies used often or always by a majority of programs are providing information to parents or guardians regarding what the evaluation will entail (88 percent), providing help accessing insurance (83 percent), scheduling the evaluation time to accommodate the parent or guardian's schedule (79 percent), providing home visits (73 percent), providing interpreters (63 percent), and providing on-site evaluation of the child (56 percent). Providing child care was the option with the highest proportion of programs where the health manager reported the support was rarely or never used (46 percent). Other strategies that are used sometimes are providing transport to appointments and having staff, such as family advocates, accompany families to the appointment.

[25] The share of health managers who responded "don't know" was typically 1 to 3 percent of respondents, but 5 percent used this response option for the child care support category. The share responding "not applicable" was typically less than 1 percent, although the range was 3 to 6 percent for the following support categories: provide interpreters, provide on-site evaluation, provide transport to appointments, and schedule to accommodate parents.

Table 8.3. Supports Offered to Encourage Parents or Guardians to Attend Follow-Up Evaluations: All Program Types

	Percentage Distribution					
Support Type	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	***[Missing, Don't Know, or Not Applicable]***
Provide on-site evaluation	5.3	6.1	32.6	28.7	27.5	*8.4*
Provide information to parents/guardians on what evaluation will entail	0.2	0.9	10.7	30.1	58.2	*6.1*
Provide transport to appointments	13.8	11.3	40.9	20.8	13.1	*8.3*
Staff (e.g., family advocates) go with families to appointments	7.9	16.4	44.9	21.1	9.6	*7.1*
Schedule evaluation time to accommodate parent/guardian schedule	0.3	2.6	18.2	37.0	41.9	*8.7*
Provide child care	26.8	18.7	25.5	14.7	14.3	*15.1*
Provide interpreters	4.4	8.8	23.6	25.1	38.0	*10.2*
Home visits	0.4	4.3	22.5	31.7	41.0	*5.0*
Provide help accessing insurance	0.0	1.1	16.2	28.9	53.8	*6.2*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 359 health manager respondents for 470 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing, unknown, or not applicable and might not sum to 100 because of rounding. The percentages of cases that are missing, unknown, or not applicable are shown for reference.

Beyond supporting parents, health managers were asked about their use of specific processes to follow up regarding the evaluations that children received, where the same strategies listed in the context of screening follow-up (Table 8.2) were again referenced, and health managers could select multiple answers. Table 8.4 records the results of this supplemental question for all HS/EHS programs and separately for HS programs and EHS programs. Across all HS/EHS programs, health managers reported an average of nearly five strategies being used (ranging from one to seven, including "other"). The most-common processes used for screening follow-up were reviewing Head Start health files, checking provider health service records, checking with parents, and following up with program staff or teachers. Use of an external evaluator is still less common, adopted by fewer than one in five programs. Relative to following up about screenings, there is a somewhat greater reliance on following up with parents about evaluations (92 percent versus 85 percent in Table 8.2). Again, the patterns are very similar across HS programs and EHS programs.

Table 8.4. Processes Used to Ensure Child Receive Follow-Up Evaluations: By Program Type

Process	All Regions, Total	All Regions, Head Start Only	All Regions, EHS Only
Processes used to ensure that children receive necessary screenings			
Average number reported (*N*)	4.6	4.6	4.5
Percentage for each process (%)			
Conducting a periodic review of child health files to ensure that follow-up evaluations were received	94.5	94.7	94.2
Following up with health care providers to obtain copy of health service record	87.3	86.7	88.3
Following up with parents/guardians to ensure that health services were received	91.9	92.1	91.6
Discussing with health staff at regular program meetings	68.0	67.4	69.1
Following up with classroom teachers	72.6	73.2	71.5
Using an external evaluator to review health records	19.2	19.7	18.4
[Missing]	*2.6*	*2.9*	*2.3*
Number of health manager respondents	359	305	186
Number of programs	470	292	178

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Additional Perspectives from Health Manager and Staff Interviews

Four key concerns emerged in the discussion of health screenings. First, while staff were trained in and felt comfortable conducting some types of screening (height and weight, vision and hearing), for programs that had large numbers of children, the lack of equipment was a challenge:

> *Our biggest challenge that we are responsible for is our screening process because there are so many children to screen. . . . We have one machine [to test vision] and 1,000 children and seven staff, so we have to rotate the machine.* —Teacher

Second, there were concerns around capacity, particularly for mental health. Screening for behavioral or mental health issues can take considerable staff time, especially when completing a lengthy, family-based trauma assessment. In some cases, higher-order neuropsychological evaluations were required, which further taxed HS/EHS staff and the broader community-based provider network. In many instances, mental health providers were in short supply, and thus HS/EHS sites had to wait considerable time for these providers to come to the center to provide on-site services. To address capacity concerns, one health manager shared that the program relied on students and staff from a neighboring university:

> *We also have health clinics ourselves. . . . Our health and family partnership manager spearheads this, and she coordinates local doctors and dentists to donate time or products. We also get help from local universities and colleges. Interns from the [university] will come, with supervisors to help with physicals, for example. This is where a lot of the manpower comes from.* —Health manager

Third, programs shared that staying ahead of screening dates and timelines could be a challenge, given other competing interests and the need to engage parents. For example, one health manager noted that the program conducted health-screening days to ensure that assessments are completed. However, with student absences, staff members had to make sure that they could capture children on non-screening days and, as a result, have the classroom coverage that allows for this. Additionally, the data systems that support timing and sequencing are helpful but have their limitations, particularly for EHS programs. Data systems, for example, may be set to automatically flag a Head Start child who is due for an annual checkup, but children in Early Head Start need to be seen every three or six months, according to the well-visit schedule. Thus, EHS health managers engage in more manual work to ensure that children are up-to-date and do not have the computer-generated safeguards to automatically flag a child who is past due.

A final concern relates to the willingness of external providers to conduct certain types of screenings. Given that HS/EHS programs rely on this broader provider network to perform certain assessments, some reluctance on the part of those providers could present difficulties. One program noted the challenge when it moved from optional to mandatory blood lead testing (as part of EPSDT requirements):

> *In our two counties, we had to work to change the mind of doctors. We were getting a lot of push back because of the change, and doctors didn't see the need for [blood lead testing], so we created a release form that doctors had to fill out explaining why they won't do it and they had to justify that. . . . This worked well and allows us to educate them on mandatory screening.* —Health manager

Also, during our interviews, HS/EHS health managers and other staff indicated that in addition to required screenings, families typically receive broader health and safety checks regarding the quality and nature of the home environment, typically as part of a home visit. In addition, some programs shared that they conduct a case-management style of intake, assessing family strengths and areas for improvement in health, nutrition, development, and parent involvement, which is used to develop family goals for the year.

Health Services and Follow-Up

In addition to health screenings, HS/EHS programs offer some medical care services on-site for the children they serve. We present findings from several survey questions addressing these topics, as well as points made on these topics in the follow-up interviews.

Health Manager Survey Responses

Table 8.5 records the share of programs that offer a list of 11 specific health services, delivered by health providers at the HS/EHS program site, including physical health, oral health, behavior or mental health, and other health-related services (e.g., nutrition, physical therapy, speech therapy, laboratory services, and general health education). Since this question was included in

the core survey, results are shown for HS/EHS programs overall and separately for HS programs and EHS programs and for Region XI AIAN programs and Region XII MSHS programs. As seen in the last response category, fewer than 4 percent of programs do not offer any of the services listed on-site. On average, close to five types of care are offered (with responses ranging from one to 12 types of care).

The most-common services offered on-site by at least a majority of HS/EHS programs are speech therapy (82 percent), behavioral or mental health care (66 percent), care or therapy for children living with disabilities (63 percent), and oral disease prevention (e.g., fluoride treatment) (60 percent). The least common on-site services are laboratory services (10 percent), immunizations (15 percent), and physical exams (19 percent). Health managers reported that about one-quarter to one-half of programs offer the other types of on-site services: nutritional care (e.g., assistance with feeding tubes) (26 percent); oral health treatment (for example, through mobile or portable dental programs) (35 percent); physical therapy (51 percent); and general health education (53 percent). These patterns are very similar for HS programs and EHS programs. Region XI AIAN programs are more likely to offer on-site oral disease prevention (88 percent) and less likely to offer on-site physical therapy (36 percent), but otherwise on-site health service provision is very similar to that in the average HS/EHS program. Compared with the average HS/EHS program, Region XII MSHS programs have a higher share offering several types of on-site services: physical exams (36 percent), immunizations (36 percent), and oral disease prevention (76 percent). Several other services are less likely to be offered on-site in Region XII MSHS programs compared with HS/EHS programs overall—specifically, behavioral or mental health care (55 percent), physical therapy (38 percent), and speech therapy (76 percent).

There are some differences, as well, based on other program characteristics (see Table H.8.5 in Appendix H). For the most part, the health manager's health-related education background is not strongly associated with the pattern of on-site medical care offerings. Immunizations are somewhat more likely to be offered on-site in programs where the health manager has a health-related degree, compared with those health managers with none (16 percent versus 9 percent), and the same is true for oral health treatment (38 percent versus 28 percent) and general health education (55 percent versus 46 percent). In the case of care or therapy for children living with disabilities, care is more likely to be offered on-site in programs where the health manager has a health-related associate degree (71 percent), compared with no degree (62 percent) or a health-related bachelor's degree (59 percent). In most cases, the rates at which services are offered do not vary with program size. Exceptions are a higher rate of offering physical exams in large programs (25 percent) than in medium or small programs (16 percent), and the same pattern holds for oral health treatment (41 percent in large programs versus 31 to 33 percent in the two smaller program-size categories). There is also some modest variation in the health care services offered on-site based on rural-urban status. In some cases, care offerings are more likely to be provided in programs in mostly rural areas than in mostly urban ones. This is the case for oral

health prevention, care for individuals living with disabilities, and speech therapy. The reverse pattern—where the prevalence of care being offered on-site is higher for programs in mostly urban areas—is found for oral health treatment (e.g., through mobile dental clinics) and nutritional care. These differences across program types are generally modest, never exceeding 10 percentage points.

Table 8.5. Types of Medical Care That Providers Deliver On-Site at HS/EHS Programs: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Types of medical care that providers come to HS/EHS program to deliver on-site					
Average number reported (*N*)	4.8	4.9	4.7	5.2	4.9
Percentage for each type of care (%)					
Physical exams	19.2	19.9	17.8	26.0	36.4
Immunizations	14.6	15.2	13.5	21.1	31.9
Oral health prevention (e.g., fluoride)	60.1	61.0	58.4	88.0	76.3
Oral health treatment (e.g., through a mobile or portable dental program)	35.1	35.5	34.4	31.6	35.3
Behavioral or mental health care (e.g., counseling, treatment)	66.3	67.7	63.9	68.9	54.8
Care or therapy for individuals living with disabilities (e.g., occupational therapy)	63.1	64.4	60.8	64.7	55.3
Nutritional care (e.g., assistance with feeding tubes)	25.8	25.0	27.4	20.3	29.0
Physical therapy	50.6	49.7	52.2	35.8	37.6
Speech therapy	82.1	84.7	77.6	88.3	75.7
Laboratory services	10.2	10.9	9.0	12.6	4.7
General health education	53.2	54.3	51.2	59.3	53.5
No medical, oral, or behavioral care is provided at the program	3.7	2.7	5.4	2.3	0.0
[Missing]	*6.3*	*6.0*	*6.8*	*12.4*	*6.4*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Just as with health screenings, ensuring that children receive follow-up health services for physical health, behavioral or mental health, or oral health more generally—whether provided on-site or off-site—is another important concern. Health managers were asked about the processes used in this regard, again with reference to the list of six processes discussed earlier in the context of health screenings and follow-up evaluations (Tables 8.2 and 8.4). Table 8.6 shows the results specific to processes for follow-up regarding physical health, behavioral or mental health, or oral health, with percentages reported for HS/EHS programs combined and

disaggregated by program type. Once again, the use of multiple strategies is the norm, with an average of about four processes used (ranging from one to seven processes, including "other") and five of the six processes used by about 65 to 65 percent of programs. As with follow-up for screenings, the top strategies are checking with the child's parent or guardian (95 percent), checking the child's health file (94 percent), and verifying the child's health service record with the provider (87 percent). About two in three programs discuss follow-up with staff (67 percent) and classroom teachers (67 percent). The use of an external evaluator continues to be a strategy used in a small minority of programs (13 percent). Again, the relative use of each strategy is very similar for HS programs and EHS programs. Region XI AIAN programs are somewhat less likely to employ each of the strategies, whereas Region XII MSHS programs are somewhat less reliant on classroom teachers and make greater use of follow-up with health staff at regular program meetings.

Table 8.6. Processes Used to Ensure Children Receive Follow-Up Health Services: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Processes used to ensure children received follow-up services for physical, behavioral, and oral health					
Average number reported (*N*)	4.3	4.3	4.3	3.7	4.3
Percentage for each process (%)					
Conduct a periodic review of child health files to ensure that follow-up service were received	94.2	94.1	94.3	85.4	97.0
Follow up with health care providers to obtain copy of health service record	86.9	86.2	88.2	71.2	89.4
Follow up with parents/guardians to ensure that services were received	94.9	95.1	94.6	91.8	88.2
Discuss with health staff at regular program meetings	66.6	66.1	67.6	49.4	77.0
Follow up with classroom teachers	67.4	68.3	65.7	62.8	51.3
Use an external evaluator to review health records	12.9	12.7	13.2	6.7	12.2
[Missing]	*6.5*	*6.2*	*7.1*	*12.4*	*9.2*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

For the most part, these patterns are quite similar across subgroups of programs defined by health manager health-related education, program size, and program rural-urban status (see Table H.8.6 in Appendix H). Where there are differences across subgroups, they are no larger than about 10 percentage points. For instance, health managers in large programs were more likely to

report using discussions with health staff at regular meetings (73 percent), compared with health managers in medium and small programs (66 percent and 61 percent, respectively). Compared with programs in mostly rural areas, programs in mostly urban areas and in mixed rural-urban areas were more likely to report conducting periodic file reviews (95 percent versus 88 percent) and discussions with staff at regular meetings (66 to 69 percent versus 58 percent). Aside from these few examples, what is striking is the similarity in the use of the Table 8.6 processes across the program subgroups we examined.

Additional Insights on Health Services and Follow-Up from Health Manager and Staff Interviews

During our interviews, most of the HS/EHS staff referenced their participation in providing referrals for a range of health and social services. In fact, they explained that this was a critical component of their position to ensure that children and families are well connected to the ancillary and support services in the community. Staff articulated that a typical process starts with the parent completing the health history. If the child is flagged with a medical need, an appropriate member of the health services team—for example, the health manager, the on-site nurse, or one of the program's health consultants—is assigned to the case. The assigned staff member or program consultant conducts the site's file review and determines whether additional discussions are required with the parent or external providers. While not all HS/EHS programs followed this protocol exactly, most offered some variation of this pathway for identifying and addressing health issues. Most staff explained that their data systems and monthly meetings provide important venues for determining that referrals are made and that families are connected to those referral agencies. One staff member explained:

> *We all do referrals when the need arises. We don't just wait for the case manager to be on-site. Depending on family circumstances, we'll refer to a resource or community agency. . . . We have a [tracking] data system and put in all referrals, home visits, etc. Everything gets entered there.* —Health manager

For other issues, such as developmental concerns or social service challenges, staff felt well equipped to connect families with a community resource or agency. Staff noted the importance of the "warm handoff" to ensure that the connection is sound and that parents have the best possible chance of follow-up. Too often, parent communication and follow-through is a challenge, and staff reported that parents often find it easier to delay follow-up, either because of competing obligations (work, other family) or simple procrastination. This issue of follow-up was cited as critical, and staff indicated a range of activities that they employ to help with the referral completion. This included accompanying parents to the appointments, offering translation services where appropriate, and helping families schedule the appointments by program staff calling providers from the HS/EHS office.

Collaboration with outside providers, particularly through these referral networks, was considered key to success. Many HS/EHS staff indicated that they participate in local provider

coalitions (above and beyond HSACs); this routine participation facilitates the cultivation of provider relationships. In addition, families signing a release for medical information at the time of Head Start enrollment allows the HS/EHS staff to have open dialogue with providers about child or family cases. Both of these elements assist with developing trust with providers and understanding child needs. One staff member described the level of community integration between family advocates and other community partners:

> *Each family advocate is supposed to have a health contact [within the partner organization], and they are supposed to make those contacts once a month. We are supposed to be on committees or in meetings related to health.* —Family service worker

In addition to providing referrals and connecting families to community resources, HS/EHS staff, including health managers, teachers, home visitors, and family service workers, all reported numerous ways that they support the family more directly. These ways included making appointments, arranging for transportation or driving, and even attending provider visits with the families.

Despite the programs' best efforts, one of the challenges with service access, mentioned in interviews and in the online survey's open-ended comments, was limits on provider availability. This was most prominent as a concern for dentists, and pediatric dentists more specifically, but it came up in the context of other providers as well.

> *It is sometimes difficult in this rural area to find specialized medical and dental care for our children without having to drive a distance—about 50 to 100 miles.* —Health manager

> *Our area lacks pediatric dentists. It also lacks dentists who participate in Medicaid. In one area that we serve, the majority of dentists will not see children who are under five years of age. Our area lacks the availability of pediatric mental health services for children and their families. The majority of mental health providers do not accept Medicaid.* —Health manager

> *In recent years, both physicians and dentist have migrated out of the city. There has also been a migration of available and accessible hospitals and clinics. The health care provider population that remained is reluctant to serve low-income families who have subsidized insurance because of the poor reimbursement.* —Health manager

Provision of Health Services and Programs in the Home

As part of the online survey, health managers were asked about the provision of health services or health programming in the homes of the children and families served by Head Start. Table 8.7 tabulates results from a series of questions regarding these home-based health services, with results shown for HS/EHS programs overall and by program type. The first entry in the table shows that 42 percent of HS/EHS programs overall offer home-based services. Consistent with the Early Head Start model, home-based health services are offered with a higher frequency in

EHS programs (59 percent) than in HS programs (33 percent). Interestingly, home-based health services are more common in Region XII MSHS programs (54 percent) and less common in Region XI AIAN programs (22 percent).

Additional tabulations by other program characteristics (see Table H.8.7 in Appendix H) show that the incidence of offering home-based services increases with the health-related education background of the health manager, from 34 percent of programs where the health manager has no health-related degree to 45 percent of programs where the health manager has a health-related bachelor's degree. There were no major differences in offering home-based services according to program size, but such services are least likely in programs in mostly rural areas (28 percent), compared with programs in mixed or mostly urban areas (46 percent and 42 percent, respectively).

Table 8.7 shows the percentage of programs offering specific types of services, among programs that offer home-based services; eight specific services were referenced in the survey, and health managers could select more than one. Just over four services were selected on average (ranging from one to eight services). Most common is teaching parents and families about supporting healthy behaviors (89 percent), followed by helping families enroll in health insurance (77 percent), teaching the child about healthy behaviors (76 percent), providing nutritional services (61 percent), and conducting health screenings (60 percent). Almost no programs provide immunizations in the home (less than 1 percent), and a minority attends to the physical health needs of children living with chronic health issues (20 percent) or provides counseling or other mental health services (42 percent). For the most part, these services are similar for HS programs and EHS programs, although the latter are somewhat more likely to conduct health screenings in the home (63 percent versus 57 percent for HS programs). Region XI AIAN programs providing home-based services are somewhat more likely to provide immunizations in the home (7 percent) but less likely to provide some of the other services in the home, such as health screenings (42 percent) and nutritional services (30 percent). Region XII MSHS programs show patterns similar to that for all HS/EHS programs, except that they are somewhat more likely to help families enroll in health insurance (84 percent) and teach parents about healthy behaviors at home (95 percent) but less likely to work directly with children on the same topic (61 percent).

Table 8.7. Health Services or Health Programs Offered in Home: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Program provides health services or health programs in the home (% distribution)					
Yes	42.0	32.6	59.0	22.1	54.4
No	55.3	64.9	38.0	73.5	42.6
Don't know	2.7	2.5	3.0	4.4	3.0
[Missing]	*6.8*	*6.5*	*7.4*	*12.4*	*11.9*
Among programs offering services in the home, which services are conducted in the home?					
Average number reported (*N*)	4.4	4.3	4.5	3.9	4.3
Percentage for each service (%)					
Conduct health screenings	60.4	57.4	63.4	42.2	59.7
Provide immunizations	0.9	0.8	1.0	7.4	0.0
Attend to the physical health needs of children living with chronic health issues	19.7	21.0	18.4	22.0	14.9
Teach children about healthy behaviors (e.g., proper toothbrushing)	76.1	74.5	77.7	74.3	61.4
Teach parents/families about supporting healthy behaviors	88.7	88.3	89.1	80.6	94.7
Provide counseling or other mental health services	41.9	41.3	42.4	42.0	45.7
Provide nutritional services	61.4	60.1	62.7	29.6	63.0
Help families enroll in health insurance	76.6	78.0	75.1	56.5	84.4
[Missing]	*1.7*	*2.7*	*0.7*	*11.7*	*0.0*
Among programs offering services in the home, what barriers are faced when providing health services or programs in the home?					
Average number reported (*N*)	4.0	4.0	3.9	3.3	3.9
Percentage for each barrier (%)					
Cultural or religious beliefs or barriers	24.2	24.4	24.0	7.1	30.2
Language barriers between HS/EHS staff and families	27.7	28.4	27.1	7.1	19.2
Literacy barriers	44.4	43.2	45.6	20.0	44.0
Parent/guardian lack of time	57.9	61.2	54.7	62.5	77.2
Parent/guardian does not understand importance of screening/treatment	73.4	73.6	73.2	53.9	66.8
Parent/guardian resistance to treatment	55.5	58.0	53.0	47.8	43.5
No physical space to conduct activities in the home	17.8	17.2	18.3	13.1	26.8
Difficulty finding a quiet space to conduct activities without interruption	30.6	28.7	32.5	20.3	26.7
Privacy concerns to discussing health-related matters in the home	16.0	14.7	17.3	6.9	15.2
Discomfort with staff in being in the home	18.0	19.2	16.9	40.5	13.8
Safety issues for staff to be in the home	24.9	26.3	23.4	32.8	19.6
[Missing]	*3.5*	*4.5*	*2.6*	*5.8*	*0.0*

Table 8.7. Health Services or Health Programs Offered in Home: By Program Type, *Continued*

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases and percentage distributions might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

The types of services offered in the home vary to some extent with the health manager health-related education background and with program rural-urban status, but not with program size (see Table H.8.7 in Appendix H). Programs where the health manager has a health-related degree are more likely to conduct health screenings, teach families about supporting healthy behaviors, provide counseling, provide nutritional services, and help families enroll in health insurance, with differences that reach at most 12 percentage points compared with programs where the health manager has no health-related degree. This may indicate that programs that offer these services are more likely to hire a health manager with health-related education or that a health manager with a health background is more apt to offer these services. Compared with programs in mostly rural areas, programs in mostly urban areas are more likely to conduct health screenings (64 percent versus 50 percent) and provide nutritional services in the home (63 percent versus 50 percent), but programs in mostly rural areas are more likely to provide immunizations in the home (7 percent versus 1 percent).

Finally, the last entry in Table 8.7 displays the percentage of health managers identifying specific barriers associated with providing health services or programs in the home.[26] Eleven challenges were listed in the online survey, and health managers could select more than one. Overall, programs reported four barriers on average (with a range from one to 11). The first six challenges pertain to issues connected with parents, such as barriers related to cultural or religious factors, language, literacy, availability, understanding of health issues, and acceptance of treatment. The other barriers relate to the unique nature of the home context, such as access to space in general, quiet space, or private space or the comfort level or safety of staff working in a home environment. Across all HS/EHS programs, the most-common barriers cited by health mangers are in the parent-related category, namely (in descending order of importance) parent or guardian not understanding the importance of screening and treatment (73 percent), parent or guardian lack of time (58 percent), and parent or guardian resistance to treatment (56 percent). Cultural or religious barriers or language barriers were cited by health managers in about one in four programs, while literacy barriers were somewhat more prevalent (44 percent). Barriers

[26] Barriers associated with the provision of physical health services, behavioral or mental health services, oral health services, and prevention and health-promotion activities are discussed later in the respective chapters on those topics.

related to the home setting appear to play a much smaller role, as each was mentioned by health managers in no more than 30 percent of programs and in most cases by fewer than one in five programs.

These patterns are replicated when HS programs and EHS programs are considered separately. In the context of Region XI AIAN programs, most of the barriers were less likely to be cited (and the average number of barriers was just above three), except for parent or guardian lack of time and discomfort of staff being in the home. For the Region XII MSHS programs, parent or guardian lack of time was even more likely to be selected as a barrier (77 percent), while most other factors were selected at rates similar to the average HS/EHS program.

Further tabulations show some differences in the barriers to offering home-based services associated with the health manager background, program size, and program rural-urban status, with differences in prevalence as large as 20 percentage points (see Table H.8.7 in Appendix H). The prevalence of several barriers is higher as the health manager education background increases—specifically, cultural or religious beliefs, language barriers, and literacy barriers—while the reverse pattern held for parent or guardian lack of time. Compared with smaller programs, health managers in larger programs were more likely to select barriers related to cultural or religious beliefs, language, resistance to treatment on the part of parents or guardians, and safety issues for the staff in the home. In contrast, discomfort with staff being in the home is more prevalent as a barrier in small programs compared with large ones. Compared with programs in mostly rural areas, a number of barriers are more likely to be mentioned by health managers in programs in mixed or mostly urban areas, namely those related to cultural or religious beliefs, language, literacy, parents or guardians understanding the importance of screening or treatment, space or quiet space for conducting activities in the home, and staff safety in the home. Barriers related to lack of parent time and discomfort with staff being in the home are more prevalent for programs in mostly rural areas.

Other Health-Related Services Provided to Families

HS/EHS programs may offer families an array of other services that have a health component, such as health-related events, workshops or classes, and assistance with enrolling in health insurance. To gain perspective on these other activities, health managers were asked to indicate whether their programs offer various other services in the eight categories listed in Table 8.8, again with the option of selecting all that applied. On average, programs reported offering approximately five of these services (ranging from no services selected to a maximum of nine services, including "other"). The most-prevalent services offered by a majority of programs include information about health insurance and assistance enrolling (91 percent), workshops on education and parenting (87 percent), health-related events for the entire family (68 percent), health and social services offered in collaboration with service agencies (e.g., hospitals) (67 percent), and health literacy services (65 percent). Other services are offered by one-half to one-

third of programs: weight management and education (54 percent), adult literacy (53 percent), and smoking cessation (36 percent). These shares are very similar for HS programs and EHS programs. Region XI AIAN programs are less likely to offer most services, with the exception of health-related events, while Region XII MSHS programs are less likely to offer smoking cessation and education and parenting workshops. A comparison in the rates of offering these services based on health manager or program characteristics shows few substantial differences (see Table H.8.8 in Appendix H).

Table 8.8. Other Health-Related Services Offered to Families by HS/EHS Programs: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Services offered by program to families					
Average number reported (*N*)	5.2	5.2	5.1	4.7	5.0
Percentage for each service (%)					
Health-related events for the entire family, including health services for other family members	68.2	68.0	68.5	69.0	71.5
Weight-management program or education	53.9	55.3	51.5	42.5	57.6
Smoking cessation	35.6	35.9	35.0	29.4	21.4
Information about health insurance and assistance enrolling	90.9	91.1	90.5	82.7	92.4
Workshops or education on parenting (e.g., classes on child development, education in being a parent, understanding children with special needs)	87.4	87.0	88.2	82.8	81.6
Adult literacy or health program (including Adult Basic Education)	53.3	55.4	49.5	40.5	55.3
Health literacy	65.3	64.7	66.3	61.8	68.4
Health or social services offered collaboratively by service agencies, such as hospitals	67.4	67.3	67.6	57.3	60.6
[Missing]	*8.3*	*7.9*	*9.1*	*13.8*	*12.5*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Health Services Provided for Pregnant Women

EHS programs were established to provide services to infants and toddlers, as well as pregnant women. To ascertain the prevalence of health-related services for pregnant women, the online survey asked health managers whether their programs offer such services, and, for those that do, health managers indicated the specific services offered from a list of 20 possible services. Because these services are most relevant for EHS programs, Table 8.9 reports the results for

EHS programs in all regions and separately for EHS programs in Region XI and Region XII. HS programs, while focused on children ages three to five, may also elect to provide services to pregnant women. However, because in many cases a single health manager responded for both an HS program and an EHS program, it is not possible to determine whether the provision of services for pregnant women reported for HS programs are because those programs are also serving EHS children and families. For this reason, we focus on the results for EHS programs only.

Table 8.9. Services Offered to Pregnant Women by EHS Programs: By Program Type

Measure	All Regions, Early Head Start Only	Region XI, Early Head Start Only	Region XII, Early Head Start Only
Program offers services to pregnant women (% distribution)			
Yes	93.9	80.0	85.1
No	4.9	16.7	14.9
Don't know	1.2	3.2	0.0
[Missing]	*8.9*	*18.9*	*20.1*
Among programs offering services to pregnant women, services offered in the program			
Average number reported (*N*)	16.2	14.6	17.0
Percentage for each service (%)			
Nutrition information	98.6	100.0	100.0
Information on how to take care of themselves during pregnancy	98.4	100.0	100.0
Information on breast-feeding	97.9	100.0	100.0
Information on how children grow and develop	97.8	92.0	100.0
Information on how to take care of babies	97.7	96.0	100.0
Postpartum services, including information on postpartum depression	96.5	84.5	93.3
A referral to a dentist for the mother	94.1	85.2	100.0
Information on how to prepare the home for a new baby	93.7	85.4	100.0
Help finding clothes, a stroller, or other baby care items	93.2	91.4	100.0
A referral to an OB, nurse/midwife, or other provider for pregnant women	87.2	67.9	93.3
A referral to a pediatrician for the baby	87.1	63.4	82.5
A referral to someone to help with breast-feeding (lactation consultant)	86.2	79.4	85.5
A referral to a pregnancy or childbirth class	84.9	65.9	93.3
Referrals for drug and alcohol cessation	84.2	69.1	90.6
A referral for smoking cessation	79.7	67.0	76.1
The chance to get together with other pregnant women or mothers	78.1	75.6	70.6
Parenting classes	73.0	80.7	76.1
A referral for a doula (or someone to help with the birthing process)	39.3	32.3	38.3
Classes for new or expectant fathers	39.2	40.6	41.3
Sibling classes	21.6	20.1	41.5
[Missing]	*0.3*	*0.0*	*0.0*
Number of health manager respondents	795	34	14
Number of programs	726	34	9

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: The list of services has been reordered from most to least prevalent among all EHS programs. Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentages of missing cases are shown for reference. OB = obstetrician.

It is important to keep in mind when interpreting the results in Table 8.9 that there are many fewer EHS programs represented among the health manager respondents in Regions XI and XII, specifically 34 EHS programs and nine EHS programs, respectively. Thus, the confidence intervals around the estimates in the table are much larger for the two regional estimates, compared with the estimate across all regions.

Overall, as seen in the first entry in Table 8.9, health managers in 94 percent of EHS programs reported offering health services for pregnant women. Table 8.9 clearly shows that EHS programs that offer services to pregnant women do so with a diverse set of supports, reporting an average of about 16 services from the list of 20 (ranging from none to 21, including "other"). Among the EHS programs offering services to pregnant women, more than 95 percent of programs offer information on nutrition, self-care during pregnancy, breast-feeding, child development, and caring for babies, as well as postpartum services (including for postpartum depression). Eighty to 95 percent of EHS programs also offer referrals to various types of health care providers: a dentist for the mother, a pediatrician, an obstetrician (OB) or midwife, or a lactation consultant, as well as referrals for other supports, such as pregnancy and childbirth classes, drug and alcohol cessation, and smoking cessation. Equally as prevalent are providing information on how to prepare the home for the new baby and help with finding clothes, a stroller, or other baby care items. Other services that are commonly offered (70 to 80 percent of EHS programs) include providing a referral for opportunities to socialize with other expecting or new mothers and for parenting classes. The services least likely to be selected (fewer than 40 percent of EHS programs) include referrals for a doula, classes for new or expectant fathers, and sibling classes.

According to health manager reports, Region XI AIAN EHS programs and Region XII MSHS EHS programs are somewhat less likely to offer services for pregnant women compared with all EHS programs (80 percent and 85 percent, respectively, versus 94 percent overall), although this might be the result of the relatively small number of respondents in those two regions. Among those programs that offer services, a similar set of services is among those mostly likely to be offered (i.e., most prevalent) and least likely to be offered (i.e., least prevalent). There may be some differences in the absolute likelihood of services being offered in Region XI and Region XII, but it is difficult to attach too much importance to the differences in the table given the small number of respondents representing EHS programs in those two regions.

Additional tabulations for EHS programs in all regions show no clear pattern in the likelihood of offering services to pregnant women based on the health manager's education-related background (see Table H.8.9 in Appendix H). Overall, EHS programs where the health manager has an associate degree are somewhat less likely to report offering services to pregnant women (91 percent), compared with programs where the health manager has no degree (99 percent) or has a bachelor's degree (94 percent). Among EHS programs offering services to pregnant women, the prevalence of offering a given service sometimes increases with the health

manager's health-related education background (e.g., a referral to an OB or a dentist), but other services are more prevalent in programs where the health manager has no health-related degree (e.g., referral to a pregnancy or childbirth class). The differences in the rate of offering specific services across subgroups defined by the health manager's background are never more than 8 to 10 percentage points. The prevalence of offering services to pregnant women does increase with EHS program size, from 92 percent for small programs to 100 percent for large programs. However, among those programs offering services to pregnant women, with one exception (referral to a pediatrician), there are no sizable differences in the likelihood of offering any specific services based on program size. Finally, there are no differences based on rural-urban status in the likelihood of EHS programs offering services to pregnant women. Among EHS programs offering services to pregnant women, there is some tendency for specific services (e.g., most types of referral services) to be provided at lower rates in programs in mostly rural areas, but the rates are highest in mixed rural-urban areas. Again, the differences across the groups defined by urbanicity are never more than about 10 percentage points.

Summary of Chapter Findings

This chapter demonstrates that HS/EHS programs offer a wide array of health services to the children and families they serve, from health screening provided primarily on-site and associated follow-up, to health services provided on-site, to home-based health services, to services for pregnant women, to other health-related supports tied to health information, health insurance, and health literacy. In each of these cases, a number of services are offered, although some are more prevalent than others. Programs also engage in various strategies to see that screenings take place, that follow-up examinations occur, and that other indicated treatment is obtained. Health managers accomplish these objectives in part by building partnerships with providers in the community, especially to perform screenings or services that HS/EHS staff are not qualified to perform or that require specialize equipment. The nature of these important partnerships with health providers—physical health, behavioral and mental health, and oral health—is the subject of the next three chapters.

In providing the array of health-related services, health managers reported a number of challenges. Some pertain to families and the need to make parents aware of the value of specific screenings, follow-up, and other services. Others relate to the capacity of in-house staff to support the services, while still others are tied to the network of providers in the community and their willingness to serve HS/EHS children and families. These challenges will also be discussed in the next three chapters in the context of the relationships with providers of physical health services, behavioral and mental health services, and oral health services.

For this chapter, responses for Region XI and Region XII programs were tabulated only for the questions regarding health services and follow-up, since those covering screening and follow-up were not included in the core questionnaire. Region XI AIAN programs were more

likely to offer oral disease prevention services on-site but less likely to provide home-based services and services for pregnant women. Region XII MSHS programs reported a higher incidence of offering on-site physical exams, immunizations, and oral disease prevention. Home-based services are also more prevalent in Region XII programs, and a relatively more prominent barrier was parent or guardian lack of time.

For these same topics, we also identified some differences based on the health manager background and other program characteristics, but the differences are generally modest, and patterns are not always consistent. For example, the provision of care services on-site was more prevalent in large programs than in small ones for two of the 11 services considered. Offering on-site care was sometimes most prevalent for programs in mostly rural areas and in other cases for programs in mostly urban areas. With a few exceptions, programs across the subgroups we examined are using a similar set of processes to ensure that children receive follow-up health services. There are also some modest differences in the likelihood of offering home-based services and the types of services offered based on the health manager health-related education background and program rural-urban status. Home-based services are least prevalent in programs in mostly rural areas. The prevalence of barriers to offering home-based services also varied to some extent with program characteristics. Finally, the likelihood of EHS programs offering services to pregnant women increases with program size but is not clearly related to the health manager health-related education background or to rural-urban status. Among programs offering services to pregnant women, most referral services are less likely to be offered by EHS programs in mostly rural areas.

9. Coordination of Physical Health Services in Head Start

Chapter Nine Methods

- HS/EHS programs are the unit of analysis
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (module 4) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups, defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.

As seen in Chapter Eight, HS/EHS programs offer a range of on-site (and sometimes off-site) health screenings, as well as on-site physical health services. Other physical health services (e.g., evaluation, treatment) are coordinated by health managers with providers for delivery off-site. Provision of such services requires the development of relationships with health care providers in the community, relationships that might take a variety of forms. In this chapter, we examine responses from the Health Manager Survey (module 4) about the coordination of physical health services with providers and agencies in the community, the nature of those partnerships, and the ability of the partnerships to meet the physical health needs of children in programs, including those children with special health care needs. We also look at the barriers that health managers cite to working with parents in providing screening and physical health services for their children. We take up a parallel set of issues and chapter structure for behavioral and mental health services in Chapter Ten and oral health services in Chapter Eleven. In reviewing health manager responses in this chapter and the two that follow, we emphasize that the Health Manager Survey was not structured to measure whether or not specific performance standards related to health services are being met.

We begin in the next section with information about the structure of the relationship that HS/EHS programs have with physical health providers. We then address the adequacy of those relationships and the nature of any barriers in working with parents in the delivery of screening and physical health services. These analyses show the following findings:

- Almost universally (97 percent), programs rely on formal mechanisms (i.e., MOUs) with physical health providers, and a majority (70 percent) combine such formal agreements with informal interactions.
- Formal relationships are most common with general health care providers in private practice or in Federally Qualified Health Centers (FQHCs), with generalists or specialists from state or local health departments, and with nutritionists.
- When formal mechanisms are in place, the partnerships with providers have a number of features. Most prominent are provisions for membership on the HSAC (69 percent), for consultation (62 percent), and for training of HS/EHS program staff (59 percent).

- Across all HS/EHS programs, the vast majority (84 percent) of program health managers stated that their partnerships with physical health providers are adequate or very adequate for meeting the physical health needs of the children they serve. A similar rating of adequacy holds for meeting the needs of children living with disabilities.
- Health managers identified a number of barriers in working with parents to obtain physical health screenings and treatment services for children. The most prevalent response was parents or guardians not understanding the importance of screening or treatment services or not being open to talking about the services. Other prominent barriers pertain to communication (e.g., phone numbers or addresses not being current) and various resource constraints (e.g., lack of transportation, lack of parental time, issues with insurance coverage). Gaps in the availability of medical providers (generalists and specialists) appear to play a smaller role.

Most of the Health Manager Survey data analyzed in this chapter derive from the supplement, which precluded separate analyses for programs in Region XI and Region XII, as well as an examination of differences by health manager and program chapters. Such disaggregated analyses were possible for the questions addressing the adequacy of the partnerships with physical health providers, and key findings regarding those results are summarized in the concluding section of the chapter.

Relationships with Physical Health Providers

To learn more about the structure of the relationships HS/EHS programs have with external providers, we asked health managers to indicate whether the mechanism for coordination of physical health services with other agencies or community partners consists of formal agreements, such as through MOUs; informal interactions; or some combination of formal agreements and informal ties. The first entry in Table 9.1 tabulates the results from this supplemental question, for all HS/EHS programs combined and separately for HS programs and EHS programs. Overall, the dominant approach for HS/EHS programs is a combination of both formal and informal mechanisms, the characterization used by health mangers in 70 percent of HS/EHS programs. Another 27 percent of programs characterized their approaches as relying on formal agreements only, while just 3 percent stated that only informal connections are in place. This outcome is virtually the same for HS programs and EHS programs.

Table 9.1. Structure of Relationship with Community Partners for Physical Health Services: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Mechanism for coordination of physical health services with other agencies or community partners (% distribution)			
Formal agreements or MOU only	26.8	26.9	26.6
Informal interactions only	3.4	3.0	4.1
Both formal agreements and informal interactions	69.8	70.1	69.3
[Don't know]	*3.1*	*2.9*	*3.4*
[Missing]	*3.0*	*3.3*	*2.3*
For those with formal mechanisms (either alone or combined with informal interactions), features included in formal partnership agreements with physical health care providers			
Average number reported (*N*)	4.6	4.6	4.6
Percentage for each feature (%)			
Resources or payments to providers	45.1	48.4	39.2
Training for HS/EHS staff	59.4	61.9	55.0
Physical health services are given to children and families at HS/EHS sites	51.7	53.0	49.6
Physical health services to HS/EHS children and families are given at other health sites/locations	54.2	54.0	54.5
Physical health services are provided for pregnant women	27.8	21.9	38.1
Joint planning	34.9	36.0	33.0
Consultation	61.6	61.1	62.3
Outreach	38.8	38.7	38.9
Membership on the HSAC	68.9	67.4	71.5
[Missing]	*3.1*	*3.0*	*3.2*
Number of health manager respondents	359	305	186
Number of programs	470	292	178

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

For those programs with formal mechanisms in place (i.e., about 97 percent of programs), health managers reported, in a follow-up supplemental question, on the features of the partnership agreements, selecting all of the relevant features from among the nine listed in the survey. As shown in the second entry in Table 9.1, nearly five features were selected on average (ranging from one to ten, including "other"). The most prevalent feature is a provision for membership on the HSAC (69 percent), followed by provisions for consultation (62 percent) and training of HS/EHS program staff (59 percent). Somewhat less common, but still relevant for a majority of HS/EHS programs, are provisions for physical health services for HS/EHS children and families at other sites (54 percent) and at the Head Start site (52 percent). Less common are provisions for resources or payments to providers (45 percent), outreach (39 percent), and joint planning (35 percent). The provision of health services for pregnant women is most relevant for EHS programs, a feature in the formal partnerships for 38 percent of EHS programs. In their agreements, HS programs are more likely to have provisions for resources or payments to

providers and training for HS/EHS staff. Otherwise, the prevalence of the other features is similar for HS programs and EHS programs.

Along with exploring the structure of the relationship with physical health providers in general, health managers were asked in a supplemental question to rate the nature of the relationship with 11 specific provider types on a four-point scale, from no working relationship (a value of zero on the rating scale) to a formal partnership or MOU (a value of three on the rating scale). A rating of one or two indicates that a program has a relationship with the provider, although it is informal and not yet formalized. In some cases, the specific type of provider is not applicable (particularly for FQHCs and the IHS), so Table 9.2 reports the distribution across the four-point rating scale only for those cases where the rating was relevant.[27]

Table 9.2. Structure of Relationship with Specific Service Providers During the Past 12 Months for the Provision of Physical Health Services: All Program Types

	Percentage Distribution				
Provider Type	**No Working Relationship [0]**	**[1]**	**[2]**	**Formal MOU/ Partnership [3]**	***[Missing or Not Applicable]***
General health care providers					
In private practice (e.g., MD, RN)	5.9	17.2	38.4	38.5	*5.1*
From local/state health departments	4.4	8.9	30.2	56.5	*5.8*
In FQHC	18.9	20.4	27.9	32.8	*30.8*
In the IHS	54.9	16.2	16.6	12.3	*65.7*
In a tribally operated health facility	58.0	12.6	13.8	15.8	*67.6*
Specialist providers					
In private practice (e.g., asthma, diabetes)	21.9	25.1	31.9	21.2	*14.2*
From local/state health departments	10.7	15.9	28.8	44.6	*12.6*
In FQHC	28.3	25.3	22.8	23.5	*39.6*
In the IHS	64.3	13.1	13.1	9.6	*68.6*
In a tribally operated health facility	65.7	14.5	9.6	10.2	*69.4*
Home-visiting providers	25.0	17.7	28.9	28.4	*33.3*
Nutritionists (e.g., registered dieticians)	0.7	5.8	13.5	80.0	*10.1*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 359 health manager respondents for 470 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing or not applicable and might not sum to 100 because of rounding. The percentages of cases that are missing or not applicable are shown for reference.

[27] The final column in Table 9.2 shows the percentage of cases with missing data or where the provider type was not applicable. The missing data rate ranges from 4 percent to 6 percent, depending on the provider type. Thus, the residual is explained by the share that is not applicable. As would be expected, the not-applicable incidence is relatively high for the FQHC (about 25 to 35 percent) and even higher for the IHS and tribally operated facilities (about 60 percent).

Table 9.2 shows that for general health care providers, relationships with those in both private practice and those in local and state health departments tend to be more formal, with health managers in 75 percent or more of programs selecting the two rating values at the formal end of the scale (i.e., a value of two or three). In contrast, when applicable, ratings for FQHCs are somewhat less formal (60 percent in the top two rating values), whereas the relationships with providers in the IHS or in a tribally operated health facility are more likely to be rated as not existing or informal. When asked about specialist providers, relationships with those in private practice and those in FQHCs are about evenly divided between informal and formal. For all HS/EHS programs, relationships with specialists in local/state health departments and with nutritionists tend to be on the more formal end of the scale, while the reverse is true again for those in the IHS or in a tribally operated health facility. Finally, relationships with home-visiting providers are weighted toward the more formal end of the scale, while relationships with nutritionists are nearly universal and are almost always reported to be formal.

Ability of Partnerships to Address Physical Health Needs and Disabilities

As part of the online survey, health managers rated the ability of their current partnerships to address the physical health needs of the children in their programs, first in general and then specifically for children living with disabilities. Results are reported in Table 9.3 and Table 9.4, respectively. The ratings are over a four-point scale, from "not adequate" to "very adequate." The percentage distribution across the rating levels excludes cases where data are missing or the health manager indicated that such partnerships are not applicable (fewer than 1 percent of cases).

Table 9.3. Ability of Partnerships to Address Physical Health Needs of Children: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Describe ability of partnerships to handle physical health needs of children in the program (% distribution)					
Not adequate	0.7	0.6	0.8	1.5	2.9
Somewhat adequate	12.4	11.7	13.6	15.0	11.5
Adequate	41.0	40.7	41.6	38.4	30.7
Very adequate	45.2	46.3	43.1	45.1	54.9
[Not applicable}	*0.7*	*0.6*	*0.9*	*0.0*	*0.0*
[Missing]	*6.4*	*6.1*	*6.8*	*12.4*	*9.2*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing or not applicable and might not sum to 100 because of rounding. The percentages of cases that are missing or not applicable are shown for reference.

Overall, it is evident that health managers generally view their relationships favorably in terms of their ability to meet children's physical health needs in general and for those living with disabilities in particular. As seen in Table 9.3, health managers in more than 85 percent of programs selected a rating of "adequate" or "very adequate" when asked about children in general. Less than 1 percent provided a rating of "not adequate," while 13 percent indicated "somewhat adequate." These shares are almost identical for HS programs and EHS programs. Health managers in Region XI AIAN programs have very similar ratings. In contrast, health managers in Region XII MSHS programs were more likely to give ratings at the extreme, with a higher share selecting "very adequate" than the overall average (55 percent versus 45 percent) and a slightly higher share stating "not adequate" (3 percent versus 0.7 percent).

A comparison with Table 9.4 shows that health managers are almost as favorable with respect to meeting the needs of children living with disabilities. More than 80 percent fall in the "adequate" or "very adequate" rating and just 1 percent in the "not adequate" category. Both Region XI AIAN programs and Region XII MSHS programs show somewhat lower ratings, but still about 75 percent selected the top two rating values, and 3 to 6 percent selected the lowest rating.

Table 9.4. Ability of Partnerships to Address Physical Needs of Children Living with Disabilities: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Describe ability of partnerships to handle needs of children in the program living with disabilities (% distribution)					
Not adequate	1.2	1.5	0.6	3.1	5.9
Somewhat adequate	14.6	15.1	13.8	23.1	18.4
Adequate	42.3	42.2	42.3	38.1	34.7
Very adequate	40.9	40.6	41.5	32.8	41.1
[Not applicable}	*1.0*	*0.6*	*1.7*	*2.9*	*0.0*
[Missing]	*6.5*	*6.2*	*7.0*	*12.4*	*9.2*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing or not applicable and might not sum to 100 because of rounding. The percentages of cases that are missing or not applicable are shown for reference.

When the measures in Tables 9.3 and 9.4 are disaggregated by other program characteristics (see Table H.9.3 and H.9.4 in Appendix H), we find few important differences based on health manager health-related education background, program size, or program rural-urban status. There is very little variation in the proportion of programs that rates partnerships as adequate or very adequate for meeting the physical health needs of the children they serve. In terms of

meeting the needs of children living with disabilities, programs in rural areas were somewhat less like to select the "adequate" or "very adequate" rating (77 percent versus 82 percent overall).

Barriers to Working with Parents for Screening and Physical Health Services

Coordination of screenings and physical health services also requires working with families, so health managers were asked to identify those factors that are major barriers to working with parents or guardians to obtain screening and treatment services related to physical health. The list of 21 barriers includes those specific to parents and issues with consent, cultural or religious beliefs, language or literacy barriers, instability in contact information, and other communication challenges. Other barriers include resource constraints, such as transportation, child care, and available time. Another set of barriers pertains to providers and their availability, as well as their cultural or linguistic competency. Several final barriers capture policy issues related to insurance or constraints on the part of HS/EHS staff in terms of time and knowledge of resources. Results for this supplemental question are shown in Table 9.5. On average, programs reported about six barriers (ranging from one to 20), and that average is similar for HS programs and EHS programs.

Although each of the barriers received some mention, several stand out as particularly prominent, specifically the parent or guardian not understanding the importance of screening or treatment services or not being open to talking about the services (74 percent) and families changing their cell phone or telephone number a lot or phone numbers that are not current (68 percent). Another cluster of issues were relevant for about 40 to 50 percent of providers, including lack of transportation or the distance to the provider office (52 percent), families moving so addresses are not current (42 percent), parent or guardian lack of time (41 percent), and issues with insurance such as no coverage, Medicaid not accepted, or out-of-pocket expenses that are too high (40 percent). Notably, issues with parent consent, cultural or religious beliefs, language barriers, and literacy barriers are not as prominent, but they are mentioned by health managers in as many as one in four programs. Barriers at the provider level such as available generalists or specialists affect about one in five programs, while cultural or linguistic competency appear to be even less prevalent. Staff constraints with time or knowledge also appear to be more minor barriers. Further, for the most part, the same issues carry similar weight in both HS programs and EHS programs.

Table 9.5. Major Barriers When Working with Parents or Guardians to Obtain Screening and Treatment Services for Physical Health: By Program Type

Barrier	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Major barriers when working with parents or guardians to obtain screening and treatment services for physical health			
Average number reported (*N*)	6.2	6.2	6.3
Percentage for each barrier (%)			
Barriers related to families and family constraints			
Not getting parental/guardian consent (permission) for screening or treatment services	19.0	20.7	16.1
Cultural or religious beliefs or barriers (e.g., male staff should not speak to female caregivers)	11.5	10.6	13.1
Language barriers between HS/EHS staff and families	11.3	11.4	11.1
Literacy barriers (reading ability or health-literacy level of parent or guardian is low)	27.0	22.9	34.2
Families move a lot/mailing addresses are not current	41.8	39.8	45.2
Families change their cell or telephone numbers a lot/phone numbers are not current	68.2	69.8	65.2
Parent/guardian does not have a telephone	30.2	31.1	28.6
Lack of transportation/distance to provider office	52.1	49.9	56.1
Lack of child care	21.1	19.8	23.2
Appointment times not available to fit parent/guardian schedule	30.4	28.8	33.2
Long wait times to get services once at provider's office	34.3	31.7	38.9
Parent/guardian lack of time	40.7	40.6	41.1
Parent/guardian does not understand importance of, does not want to talk about, or resists screening/treatment	74.2	76.3	70.5
Barriers related to providers			
Lack of available generalist providers (e.g., pediatricians, dentists)	21.7	22.8	19.9
Lack of specialist providers	21.2	22.8	18.4
Lack of culturally competent providers	8.3	7.0	10.7
Language barriers between families and providers	17.0	15.6	19.5
Barriers related to insurance policies and program constraints			
Insurance and out-of-pocket costs (e.g., no health insurance, Medicaid not accepted, out-of-pocket expenses too high)	39.7	42.0	35.6
Limited Medicaid transferability across state lines	9.0	10.4	6.7
Lack of staff time to follow up	15.9	16.6	14.5
HS/EHS staff lack knowledge of resources	3.6	4.1	2.6
[Missing]	*3.4*	*3.4*	*3.5*
Number of health manager respondents	359	305	186
Number of programs	470	292	178

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Summary of Chapter Findings

The survey responses presented in this chapter provide insight into the nature of the relationships that HS/EHS programs have with physical health providers. For almost all HS/EHS programs, partnerships are based on formal mechanisms, with features that indicate strong ties, such as providers serving on HSACs, assisting with staff training, and providing physical health services

at the HS/EHS site or at other sites. There are differences in the degree of formality across different types of physical health providers, but the most-formal ties are associated with the general health providers or specialists who are most relevant for the majority of HS/EHS programs. Most important, health managers in four out of five programs rated their partnerships with physical health providers as adequate or better for meeting the physical health needs of the children they serve. These patterns are generally similar for HS programs and EHS programs.

Health managers also indicated that there are a number of salient challenges in their work with parents to ensure that children receive the physical health screening and treatment services they need. Although there may be more that health managers can do to support parents and the challenges they face in securing adequate physical health care for their children, this could require overcoming the issues mentioned with respect to having current contact information for parents and other challenges facing families, such as a lack of transportation and low resources.

For the two survey questions that were asked of all health managers regarding the adequacy of their partnerships with physical health providers for meeting the needs of the children the programs serve in general and specifically for those living with disabilities, health managers in programs in Region XI AIAN and Region XII MSHS were somewhat less likely to state that the partnerships are adequate or very adequate for meeting the physical health needs of children living with disabilities. Even so, almost 75 percent of Region XI AIAN programs and Region XII MSHS programs rated their partnerships in these categories as adequate or better, and very few selected the "not adequate" rating. That relatively high rating should not detract from the fact that additional supports may be needed to help Region XI and Region XII programs improve partnerships with physical health providers. In terms of other program characteristics, the differences in the ratings regarding adequacy are fairly modest.

10. Coordination of Behavioral and Mental Health Services in Head Start

In this chapter, we explore a similar set of issues as the prior chapter, this time with respect to the coordination of behavioral and mental health services (module 4). As with the prior chapter, it is important to keep in mind that the survey was not designed to determine whether HS/EHS programs are meeting specific performance standards with respect to behavioral and mental health services but rather to focus on the nature of the partnerships with providers, their adequacy, and barriers faced in the provision of these services.

Chapter Ten Methods

- HS/EHS programs are the unit of analysis
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (module 4) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups, defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.

The next section starts with a look at the structure of the relationships that HS/EHS programs have with behavioral and mental health providers. We also report on health managers' assessments of the adequacy of those relationships to meet the behavioral and mental health needs of children in their programs. We conclude by examining the barriers that health managers identify in working with parents in the delivery of behavioral and mental health services.

Keeping in mind the parallels with the survey responses in Chapter Nine regarding physical health services, we note the following key similarities and differences for behavioral and mental health services:

- As with physical health services, almost all partnerships with behavioral or mental health providers (94 percent) rely on formal mechanisms, such as MOUs, and this is especially true for partnerships with state and local agencies providing behavioral or mental health prevention and treatment services and with private for-profit or nonprofit behavioral or mental health providers.
- Formal partnerships are most likely to include provision of behavioral or mental health services to children and families at HS/EHS sites (83 percent), training for HS/EHS staff (80 percent), consultation (79 percent), and provision for behavioral or mental health services at other sites (62 percent).
- Compared with partnerships with physical health providers, health managers were somewhat less likely to state that their partnerships with behavioral or mental health

providers are adequate or very adequate for addressing the behavioral or mental health needs of the children in their programs (76 percent versus 84 percent for physical health).

- When identifying barriers to working with parents to obtain behavioral or mental health services, the same issues rose to the top as those mentioned in the context of physical health services—specifically, parent engagement (i.e., understanding the importance of or being willing to discuss the health services) and up-to-date parent contact information (e.g., current phone numbers). The lack of available behavioral or mental health specialists is a lesser concern but still affects about one in four programs.

As with Chapter Nine, we were able to explore differences in the perceptions of partnership adequacy for programs in Region XI and Region XII, as well as by health manager and program characteristics. The results of those analyses are summarized in the final section of the chapter.

Relationships with Behavioral and Mental Health Providers

Health managers were asked in a supplemental question to indicate whether formal or informal mechanisms, or both, governed their coordination of behavioral health services with other agencies and community partners. The first entry in Table 10.1 demonstrates that both formal and informal mechanisms for coordination prevail for 60 percent of HS/EHS programs, while another 34 percent rely on formal agreements only, such as MOUs. As with physical health services, it is relatively rare for programs to rely solely on informal connections (6 percent versus 3 percent for physical health services). HS programs and EHS programs both display this pattern. The second entry in Table 10.1 shows how health managers responded to a follow-up supplemental question for the 94 percent of programs that use formal mechanisms at least some of the time, referencing eight of the nine features examined in the case of formal agreements with physical health providers (see Table 9.1).[28] For behavioral health agreements, health managers reported an average of five features (ranging from one to eight). The top feature is the provision of behavioral or mental health services to children and families at HS/EHS sites (83 percent), followed closely by training for HS/EHS staff (80 percent) and consultation (79 percent). A provision for behavioral or mental health services for children and families at other sites is also included in agreements for a majority of programs (62 percent). Other features—resources or payments to providers and services for pregnant women—are included in agreements with 40 to 50 percent of providers. A provision for outreach is least likely to be included in agreements with behavioral or mental health providers (38 percent). Notably, with the exception of outreach, agreements with behavioral or mental health providers are more likely to include each of the features listed in Table 10.1, compared with agreements with the providers' physical health counterparts (Table 9.1). For example, 80 percent of formal agreements with behavioral or mental health providers have a provision for training HS/EHS

[28] Membership on the HSAC was not included as a response option in the question regarding behavioral health providers.

staff, compared with 59 percent of formal agreements with physical health providers. As with physical health providers, the main contrast between HS programs and EHS programs is that behavioral health provider agreements for the latter are more likely to include provision for services to pregnant women (70 percent versus 34 percent).

Table 10.1. Structure of Relationship with Community Partners for Behavioral and Mental Health Services: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Mechanism for coordination of behavioral health services with other agencies or community partners (% distribution)			
Formal agreements or MOUs only	34.2	32.7	36.8
Informal interactions only	5.9	6.0	5.7
Both formal agreements and informal interactions	60.0	61.3	57.6
[Don't know]	*6.6*	*5.9*	*7.8*
[Missing]	*5.5*	*5.0*	*6.5*
For those with formal mechanisms (either alone or combined with informal interactions), features included in partnership agreements with behavioral or mental health care providers			
Average number reported (*N*)	5.0	4.8	5.2
Percentage for each feature (%)			
Resources or payments to providers	49.0	46.0	54.4
Training for HS/EHS staff	80.2	80.2	80.2
Behavioral or mental health services are given to children and families at HS/EHS sites	83.3	83.0	83.8
Behavioral or mental health services to HS/EHS children and families are given at other health sites/locations	61.7	60.3	64.4
Behavioral or mental health services are provided for pregnant women	46.5	33.9	69.7
Joint planning	47.4	47.2	47.8
Consultation	78.8	78.7	79.0
Outreach	36.9	40.5	30.4
[Missing]	*1.5*	*1.9*	*0.6*
Number of health manager respondents	359	305	186
Number of programs	470	292	178

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Health managers were also asked to rate the nature of the relationship with seven types of behavioral or mental health providers, using a four-point scale that ranges from no working relationship to a formal partnership or MOU.[29] The results for this supplemental question are included in Table 10.2 for all HS/EHS programs. Overall, relationships with state or local agencies providing behavioral or mental health prevention and treatment services are most likely to be structured as formal partnerships (more than 80 percent in the upper half of the scale). More-formal partnerships are also the norm with private and for-profit behavioral or mental health providers, such providers in nonprofit agencies and other behavioral or mental health consultants. HS/EHS programs, on average, are least likely to have working relationships with behavioral or mental health providers in hospitals, in the IHS, or in a tribally operated health facility. Relationships with home-visiting providers are about equally divided between more-informal and more-formal structures, similar to the finding for physical health providers.

Table 10.2. Structure of Relationship with Specific Service Providers During the Past 12 Months for the Provision of Behavioral and Mental Health Services: All Program Types

	Percentage Distribution				
Provider Type	**No Working Relationship [0]**	**[1]**	**[2]**	**Formal MOU/ Partnership [3]**	***[Missing or Not Applicable]***
State or local agency/agencies providing behavioral or mental health prevention and treatment services	4.6	12.8	19.6	63.2	*14.7*
Private, for-profit behavioral or mental health providers	16.0	17.8	19.4	46.6	*17.0*
Behavioral or mental providers in hospitals	47.5	23.7	17.2	11.8	*30.7*
Behavioral or mental health providers in nonprofit agencies	13.3	20.4	28.3	38.0	*20.0*
Home-visiting providers	28.9	18.0	28.1	25.2	*33.8*
Behavioral or mental health providers in the IHS	63.7	12.2	14.5	9.9	*69.7*
Behavioral or mental health providers in a tribally operated health facility	65.2	9.6	11.7	13.1	*71.8*
Other behavioral or mental health consultants	10.2	12.0	18.8	59.1	*67.5*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 359 health manager respondents for 470 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing or not applicable and might not sum to 100 because of rounding. The percentages of cases that are missing or not applicable are shown for reference.

[29] These ratings and the associated percentage distributions are provided only when applicable. The last column in Table 10.3 shows the percentage of cases with missing data or where the provider type was not applicable. The missing data rate varies from 8 percent to 10 percent, so the remainder is the share of programs where the provider type is not applicable. About 60 percent of programs do not have a relationship with a provider in the IHS or a provider in a tribally operated health facility (last two rows), so fewer respondents rated the relationship for these two provider types.

Ability of Partnerships to Address Behavioral and Mental Health Needs

Health managers were asked, as with physical health providers, to rate the ability of their partnerships with behavioral and mental health providers to meet the health needs of the children they serve. The responses to this question are included in Table 10.3 in total and disaggregated by program type. The distribution of responses from "very adequate" to "not adequate" is calculated exclusive of missing cases and the small fraction of cases where such relationships are not applicable (no more than 1 percent of cases). As with physical health providers, health managers in a majority of HS/EHS programs overall classified their relationships as "very adequate" (26 percent) or "adequate" (49 percent), but the combined total is somewhat below the favorable rating given to physical health providers (see Table 9.3). A small percentage, 4 percent, provided a "not adequate" rating, but, together with those in the "somewhat adequate" group (21 percent), about one in four programs falls in the less-than-adequate end of the spectrum. These shares are quite similar for HS programs and EHS programs and for Region XII MSHS programs. Region XI AIAN programs are somewhat more likely to give below-adequate ratings (about 34 percent), with health managers in nearly 10 percent of programs stating that the partnerships are "not adequate" to address the behavioral health needs of the children in their programs. The differences by other program characteristics are far less striking (see Table H.10.3 in Appendix H), with no more than 6 percent of any subgroup rating partnerships as not adequate (where the maximum 6 percent rate applies to programs in mostly rural areas).

Table 10.3. Ability of Partnerships to Address Behavioral and Mental Health Needs of Children: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Describe ability of partnerships to handle behavioral or mental health needs of children in the program (% distribution)					
Not adequate	3.7	3.5	4.2	9.5	2.9
Somewhat adequate	20.5	20.5	20.4	24.0	23.5
Adequate	49.1	50.5	46.5	46.5	49.8
Very adequate	26.0	25.1	27.7	20.0	23.8
[Not Applicable}	*0.7*	*0.4*	*1.2*	*0.0*	*0.0*
[Missing]	*7.1*	*6.9*	*7.4*	*12.4*	*9.2*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing or not applicable and might not sum to 100 because of rounding. The percentages of cases that are missing or not applicable are shown for reference.

Barriers to Working with Parents for Behavioral and Mental Health Services

A final supplemental question prompted health managers to select the major barriers in working with parents or guardians to obtain screening and treatment services for behavioral or mental health. The same set of 21 possible barriers, discussed earlier in the context of physical health providers, relating to the family context, provider context, and HS/EHS staff, were included. Results are shown in Table 10.4 for HS/EHS programs overall and separately for HS programs and EHS programs. As with physical health services, programs reported, on average, about six barriers for all HS/EHS programs (ranging from one to 18 barriers) and separately for HS programs and EHS programs.

Once again, the same two barriers received the most mentions: the parent or guardian not understanding the importance of screening or treatment services or unable to talk about the services (70 percent) and problems with having a current phone number with which to contact the family (52 percent). Other top factors again include issues with transportation (39 percent), lack of parental time (34 percent), and insurance coverage or out-of-pocket costs (30 percent). The same issues that were less prevalent in the context of physical health care—parent consent, cultural and religious beliefs, language and literacy, provider availability or cultural or linguistic competency, and HS/EHS staff constraints—were also less likely to be mentioned in the context of behavioral and mental health services but still affect a nontrivial share of programs. The lack of available mental or behavioral health specialists, for example, was mentioned by health managers in nearly one in four programs. Again, these patterns are replicated in the responses when tallied separately for HS programs and EHS programs.

Summary of Chapter Findings

This chapter places a spotlight on partnerships between HS/EHS programs and behavioral and mental health providers, demonstrating that they have many of the same characteristics as partnerships with physical health providers (see Chapter Nine). Such partnerships, for the most part, rely on formal mechanisms, such as MOUs, to establish the nature of the relationship. Behavioral and mental health providers are actively engaged with HS/EHS programs through screenings, service delivery, training, parent education, and other roles. For the majority of programs, such partnerships are judged to be adequate or very adequate for meeting the behavioral and mental health needs of the children they serve. Nevertheless, it is important to recognize that health managers in almost 25 percent of programs reported having less than adequate partnerships, so there is opportunity to build stronger ties between HS/EHS programs and behavioral and mental health practitioners. Likewise, we have seen that health managers point to a consistent set of issues in working with parents, whether they are addressing physical health needs of children or behavioral and mental health needs.

Table 10.4. Major Barriers When Working with Parents or Guardians to Obtain Screening and Treatment Services for Behavioral and Mental Health: By Program Type

Barrier	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Major barriers when working with parents or guardians to obtain necessary screening and treatment services for behavioral or mental health			
Average number reported (*N*)	5.5	5.4	5.7
Percentage for each barrier (%)			
Barriers related to families and family constraints			
Not getting parental/guardian consent (permission) for screening or treatment services	33.3	36.5	27.6
Cultural or religious beliefs or barriers (e.g., male staff should not speak to female caregivers)	13.6	11.1	17.9
Language barriers between HS/EHS staff and families	11.0	10.8	11.5
Literacy barriers (reading ability or health-literacy level of parent or guardian is low)	18.9	16.0	24.0
Families move a lot/mailing addresses are not current	31.5	30.6	33.1
Families change their cell or telephone numbers a lot/phone numbers are not current	51.5	53.9	47.2
Parent/guardian does not have a telephone	24.8	24.9	24.7
Lack of transportation/distance to provider office	38.7	34.4	46.2
Lack of child care	18.7	16.2	23.1
Appointment times not available to fit parent/guardian schedule	27.2	25.4	30.3
Long wait times to get services once at provider's office	21.9	19.2	26.6
Parent/guardian lack of time	34.2	32.7	36.8
Parent/guardian does not understand importance of, does not want to talk about, or resists screening/treatment	69.8	70.6	68.2
Barriers related to providers			
Lack of available generalist providers (e.g., pediatricians, dentists)	10.8	12.6	7.6
Lack of specialist providers	23.4	25.9	18.9
Lack of culturally competent providers	10.9	9.5	13.4
Language barriers between families and providers	15.7	14.3	18.2
Barriers related to insurance policies and program constraints			
Insurance and out-of-pocket costs (e.g., no health insurance, Medicaid not accepted, out-of-pocket expenses too high)	29.8	30.0	29.5
Limited Medicaid transferability across state lines	6.0	6.7	4.8
Lack of staff time to follow up	11.4	11.1	11.9
HS/EHS staff lack knowledge of resources	3.7	3.7	3.6
[Missing]	*7.1*	*7.2*	*6.9*
Number of health manager respondents	359	305	186
Number of programs	470	292	178

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

As with Chapter Nine, analysis of Region XI AIAN programs and Region XII MSHS programs, as well as differences by other program characteristics, is feasible only for the question regarding the adequacy of partnerships with behavioral and mental health providers. Compared with all HS/EHS programs, health managers in Region XI AIAN programs were somewhat more likely (34 percent versus 24 percent) to give a less-than-adequate rating, suggesting the need to improve both the number and quality of such partnerships in AIAN

programs. There was no such difference for Region XII MSHS programs. Likewise, there were no substantial differences in the adequacy ratings based on the health manager health-related education background, program size, or program urbanicity.

11. Coordination of Oral Health Services in Head Start

We now turn to issues related to the coordination of oral health services in Head Start (module 4), with similar topics to those just discussed for physical health services (Chapter Nine) and behavioral and mental health services (Chapter Ten). As with the prior two chapters, our interest is the nature of the partnerships between HS/EHS programs and oral health providers, the adequacy of those relationships, and any relevant barriers in the context of oral health services. The survey was not designed to ascertain compliance with specific oral health performance standards.

Chapter Eleven Methods

- HS/EHS programs are the unit of analysis.
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (module 4) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups, defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.

We begin in the next section with findings regarding the structure of the relationships that HS/EHS programs have with oral health providers. Then we examine health managers' assessments of the adequacy of those partnerships to meet the oral health needs of children in their programs. The subsequent section considers the barriers that health managers cite in working with parents in the delivery of oral health services. Keeping in mind the findings from the two prior chapters, we identify the following findings:

- Compared with physical health services and behavioral and mental health services, HS/EHS programs are less likely to have formal relationships with oral health providers (80 percent for oral health versus 97 and 94 percent for physical health services and behavioral and mental health services, respectively). Formal partnerships are most prevalent with dentists and dental hygienists in private practice or state or local health departments, as well as with portable or mobile dental practices.
- When formal mechanisms with oral health providers exist, there are a number of typical features, such as providing oral health services for children and families in HS programs (57 percent) and services for children from birth to age three and pregnant women in EHS programs (55 percent). Provision for resource payments to providers are included in about one-half of formal partnership agreements.
- In terms of adequacy, health managers were about equally likely to rate their partnerships with oral health providers as adequate or very adequate for meeting needs as they were for behavioral and mental health providers (76 percent in each case). This is somewhat below the adequacy rating for partnerships with physical health providers (84 percent).

- Once again, when asked to identify issues in working with parents to obtain oral health services for their children, two barriers received the most mentions: parent lack of understanding or willingness to discuss screening and treatment and up-to-date parent contact information. Other secondary barriers that were mentioned, which are similar to those mentioned for physical and behavioral/mental health, include transportation gaps, parental time constraints, and insurance coverage gaps. Shortages of dentists (generalists and specialists) was an issue mentioned in about one in four programs.

As with the two prior chapters, where they could be explored, we feature relevant differences for programs in Region XI and Region XII, as well as differences by health manager and program characteristics, in the concluding section of the chapter.

Relationships with Oral Health Providers

In a supplemental question, health managers were asked to indicate whether they coordinate oral health services with community partners through formal agreements, informal interactions, or both. The percentage distribution across these three options is reported in Table 11.1, in the first entry for HS/EHS programs combined and separately for HS programs and EHS programs. As with providers in the physical health and behavioral and mental health domains, the dominant arrangement for oral health service providers is reliance on both formal agreements and informal interactions, the approach used by 61 percent of programs. However, in contrast to partnerships with physical health providers and behavioral or mental health providers, where reliance exclusively on informal interactions was quite rare (just 3 percent and 6 percent of programs, respectively; see Table 9.1 and Table 10.1), about 24 percent of HS/EHS programs base their oral health partnerships on informal interaction only. A nearly equal share (18 percent) rely on just formal agreements. This greater incidence of exclusively having informal interactions with oral health providers is a pattern replicated for both HS programs and EHS programs.

The lower portion of Table 11.1 also shows the features of the formal mechanisms with oral health providers for the 79 percent of programs with such relationships (i.e., the 18 percent with formal agreements only and the 61 percent with both formal agreements and informal interactions). About four features were selected on average (ranging from one to 11, including "other"). Of the ten provisions referenced in the survey, seven are applicable to both HS and EHS programs. Of these, the most prevalent feature is a provision for oral health services for children and families at HS/EHS sites (57 percent), followed by a provision for such services at other sites (51 percent). Another feature common to about one-half of all HS/EHS programs is a provision for resources or payments to providers (49 percent), a share that is similar to that for such resources in formal agreements with physical health providers (Table 9.1) and behavioral or mental health providers (Table 10.1). Other features of formal agreements with oral health providers are relevant for a minority of programs, such as training for HS/EHS staff (43 percent), consultation (40 percent), outreach (27 percent), and joint planning (18 percent). For these seven features, the patterns are similar across HS and EHS programs.

Table 11.1. Structure of Relationship with Community Partners for Oral Health Services: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Mechanism for coordination of oral health services with other agencies or community partners (% distribution)			
Formal agreements or MOUs only	18.0	17.1	19.5
Informal interactions only	20.9	22.6	17.9
Both formal agreements and informal interactions	61.1	60.3	62.6
[Don't know]	*3.0*	*2.1*	*4.5*
[Missing]	*6.9*	*7.1*	*6.5*
For those with formal mechanisms (either alone or combined with informal interactions), features included in partnership agreements with oral health care providers			
Average number reported (*N*)	4.3	4.1	4.5
Percentage for each feature (%)			
Applicable for HS and EHS programs			
Resources or payments to providers	49.0	48.1	50.5
Training for HS/EHS staff	43.3	39.6	49.6
Oral health services are given to children and families at HS/EHS sites	56.9	57.6	55.6
Oral health services to HS/EHS children and families are given at other health sites/locations	51.0	53.5	46.9
Joint planning	18.2	20.5	14.3
Consultation	39.5	41.1	36.8
Outreach	27.2	30.9	20.9
Applicable for EHS programs			
Oral health services provided to young children, ages 0–3, at HS/EHS sites	54.6	47.4	66.9
Oral health services provided to young children, ages 0–3, at other health sites/locations	43.5	39.1	51.1
Oral health services are provided for pregnant women	34.9	24.0	53.6
[Missing]	*0.8*	*1.1*	*0.3*
Number of health manager respondents	357	305	200
Number of programs	465	286	179

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Three of the features listed in Table 11.1 are relevant for EHS programs because they are specific to children ages zero to three and pregnant women. Among the 83 percent of EHS programs with formal agreements with oral health providers, 67 percent reported having a feature for the provision of oral health services at their program sites, and 51 percent reported having a provision for such services at another site. The provision of oral health services for pregnant women is a feature included in the formal agreements for 54 percent of EHS programs. These features are also mentioned by health managers in up to 24 percent of HS programs, again because the health managers were likely responding about their combined HS and EHS programming.

Health managers were also asked to rate the structure of their relationships with specific types of oral health service providers, as they had done with physical health providers and behavioral or mental health service providers. The results are reported in Table 11.2, again using a four-point scale, from no working relationship (value of zero) to a formal partnership or MOU (value of three). The percentage distributions across the four-point scale exclude cases with missing data and where the health manager indicated that the provider type is not applicable.[30] Overall, the results show that more-formal partnerships (rating of two or three) with oral health providers are most likely to be in place for dentists in private practice or from a local or state health department (70 percent and 55 percent, respectively), for dental hygienists in private practice or from a local or state health department (48 percent and 51 percent, respectively), and for physicians in private practice or in a public health clinic (69 percent and 71 percent, respectively). All other provider types listed in Table 11.2 are more likely to be less formal, either with no relationship or a more informal relationship. In particular, having no working relationship is most prevalent for oral health providers in FQHCs (50 to 57 percent), with the IHS (64 to 68 percent), and in a tribally operated dental facility (72 to 75 percent), as well as for dental schools (54 percent) and dental hygiene schools or programs (56 percent).

Ability of Partnerships to Address Oral Health Needs

As with physical health providers and behavioral and mental health providers, health managers rated the adequacy of their programs' partnerships with oral health providers in terms of meeting the oral health needs of children in the programs. The results are tabulated in Table 11.3, exclusive of those cases with missing data or where the health manager indicated that such relationships are not applicable (no more than 1 percent of cases). Overall, health managers in 76 percent of HS/EHS programs rated their partnerships as "very adequate" or "adequate" for meeting the oral health needs of the children. The share with a "very adequate" response was higher for oral health providers (38 percent) compared with the same ratings for behavioral or mental health partnerships (26 percent; see Table 10.4) and about the same compared with physical health providers (41 percent; see Table 9.4). Just 4 percent stated that the relationship with oral health providers is "not adequate," about the same as the rating for behavioral and mental health providers. When combined with those giving a "somewhat adequate" rating, almost one in four programs rated their partnerships as less than adequate. The ratings by health managers in HS programs and EHS programs are very similar. The share in the "adequate" to "very adequate" range is likewise about the same for Region XI AIAN programs and Region XII

[30] The last column in Table 11.2 reports the percentage of cases with missing values or where the provider type was not applicable. The missing data rate ranges from 7 percent to 8 percent, depending on the provider type. The residual is the percentage of programs where the provider type is not applicable. That rate is highest for oral health providers in the IHS or in a tribally operated facility (about 50 to 55 percent), so fewer respondents rated the relationship for those provider types.

MSHS programs. When the ratings are viewed for subgroups defined by other program characteristics (see Table H.11.3 in Appendix H), there are no marked differences.

Table 11.2. Structure of Relationship with Specific Service Providers During the Past 12 Months for the Provision of Oral Health Services: All Program Types

	Percentage Distribution				
Provider Type	No Working Relationship [0]	[1]	[2]	Formal MOU/ Partnership [3]	*[Missing or Not Applicable]*
Dentists					
In private practice	13.6	16.7	25.6	44.1	*8.9*
From local/state health departments	32.4	12.5	24.0	31.1	*27.2*
In FQHC	49.7	11.4	16.7	22.1	*41.7*
With the IHS	64.3	9.7	10.7	15.2	*59.0*
In a tribally operated dental facility	71.6	6.6	10.4	11.4	*61.0*
Dental hygienists					
In private practice	37.4	14.9	17.8	29.9	*28.3*
From local/state health departments	40.1	8.8	18.9	32.3	*35.5*
In FQHC	56.6	14.9	12.1	16.4	*48.8*
With the IHS	68.1	6.2	7.4	18.3	*60.7*
In a tribally operated dental facility	74.9	5.6	5.1	14.4	*61.8*
Portable/mobile dental practices	33.9	11.2	18.8	36.1	*32.4*
Dental schools	53.6	11.4	18.0	16.9	*41.2*
Dental hygiene schools or programs	56.4	12.6	15.8	15.2	*39.7*
Physicians in private practice	16.3	14.7	37.2	31.9	*14.5*
Physicians in public health clinics (e.g., from local/state health departments, FQHCs)	17.3	11.6	27.6	43.5	*20.3*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 357 health manager respondents for 465 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing or not applicable and might not sum to 100 because of rounding. The percentages of cases that are missing or not applicable are shown for reference.

Barriers to Working with Parents for Oral Health Services

Health managers were asked about the same set of potential major barriers to working with parents and guardians regarding oral health screening and treatment services as for physical health and behavioral and oral health. Table 11.4 records the percentage of health managers that selected each potential barrier from the list of 21 barriers pertaining to family context, provider context, and HS/EHS staff. Close to six barriers were selected on average (ranging from one to 16). As with the other two health domains, two barriers were most likely to be selected: the parent or guardian not understanding the importance of screening or treatment services or not able to talk about the services (70 percent) and problems with having a current phone number with which to contact the family (57 percent). Other prominent factors again included issues with transportation (52 percent), lack of parental time (40 percent), and insurance coverage or out-of-pocket costs (40 percent). Issues of lesser importance, but still affecting 20 percent or more of programs, include literacy barriers, mailing addresses that are not current or families that do not

have phones, long waiting times for services, and lack of available generalists and specialists. A shortage of pediatric dentists was a common issue voiced in the interviews (see Chapter Eight), so the survey responses confirm that this barrier affects a nontrivial share of programs. These results are replicated when HS programs and EHS programs are considered separately.

Table 11.3. Ability of Partnerships to Address Oral Health Needs of Children: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Describe ability of partnerships to handle oral health needs of children in the program (% distribution)					
Not adequate	4.2	3.7	5.0	1.5	0.0
Somewhat adequate	19.4	18.7	20.7	22.2	22.6
Adequate	38.2	38.9	36.9	35.7	37.2
Very adequate	37.3	37.9	36.2	40.6	40.2
[Not applicable}	*1.0*	*0.8*	*1.2*	*0.0*	*0.0*
[Missing]	*6.9*	*6.5*	*7.4*	*12.4*	*9.2*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing or not applicable and might not sum to 100 because of rounding. The percentages of cases that are missing or not applicable are shown for reference.

Summary of Chapter Findings

When compared with their partnerships with physical health providers and behavioral and mental health providers, HS/EHS programs are somewhat less likely to have formal partnerships in place with oral health providers. The differences are not large, but they do signal that oral health partnerships may be less well established than other health-related provider partnerships. The Health Manager Survey responses also demonstrate that health managers in about three out of four programs rated their partnerships with oral health providers in the adequate or better range, which, like the behavioral health ratings, suggests that there is room for strengthening such partnerships. We also see a commonality across physical health, behavioral and mental health, and oral health in the barriers that health managers identify in working with families. This suggests that there may be great synergies if those issues of parent engagement, communication, and other resource constraints can be addressed. For the most part, these patterns for HS/EHS combined are replicated when we consider HS programs and EHS programs separately.

The patterns of responses for Region XI and Region XII programs can be ascertained only for the rated adequacy of partnerships with oral health providers. In that regard, health managers in those two regions are about equally likely as programs nationally to indicate that the partnerships are adequate or more than adequate to meet children's oral health needs. Likewise, comparisons across programs based on health manager health-related education, program size,

and program rural-urban status show few important differences in the nature of formal partnerships for oral health.

Table 11.4. Major Barriers When Working with Parents or Guardians to Obtain Screening and Treatment Services for Oral Health: By Program Type

Barrier	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Major barriers when working with parents or guardians to obtain necessary screening and treatment services for oral health			
Average number reported (*N*)	5.9	6.0	5.8
Percentage for each barrier (%)			
Barriers related to families and family constraints			
Not getting parental/guardian consent (permission) for screening or treatment services	18.9	21.8	13.7
Cultural or religious beliefs or barriers (e.g., male staff should not speak to female caregivers)	7.5	7.9	6.8
Language barriers between HS/EHS staff and families	11.4	11.4	11.2
Literacy barriers (reading ability or health-literacy level of parent or guardian is low)	19.8	19.8	19.7
Families move a lot/mailing addresses are not current	30.5	31.3	28.9
Families change their cell or telephone numbers a lot/phone numbers are not current	56.5	59.2	51.5
Parent/guardian does not have a telephone	19.7	20.5	18.1
Lack of transportation/distance to provider office	52.1	49.9	55.9
Lack of child care	18.1	17.3	19.4
Appointment times not available to fit parent/guardian schedule	30.3	30.4	30.0
Long wait times to get services once at provider's office	25.8	25.5	26.3
Parent/guardian lack of time	40.3	40.9	39.2
Parent/guardian does not understand importance of, does not want to talk about, or resists screening/treatment	70.4	70.3	70.7
Barriers related to providers			
Lack of available generalist providers (e.g., pediatricians, dentists)	24.2	24.2	24.3
Lack of specialist providers	27.6	29.0	25.1
Lack of culturally competent providers	8.0	7.5	8.8
Language barriers between families and providers	14.7	14.8	14.6
Barriers related to insurance policies and program constraints			
Insurance and out-of-pocket costs (e.g., no health insurance, Medicaid not accepted, out-of-pocket expenses too high)	39.7	40.3	38.7
Limited Medicaid transferability across state lines	5.7	5.7	5.8
Lack of staff time to follow up	18.8	17.4	21.3
HS/EHS staff lack knowledge of resources	2.2	2.4	1.9
[Missing]	*7.1*	*7.6*	*6.3*
Number of health manager respondents	357	305	200
Number of programs	465	286	179

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

12. Health-Promotion Activities in Head Start

In this chapter, we turn our attention to prevention and health-promotion activities in HS/EHS programs for children, families, and staff. Module 4 in the Health Manager Survey included a series of questions about health promotion and prevention services (most of which were in the survey supplement), while module 5 included a few questions about staff-wellness supports (also in the supplement). In the area of health promotion, the Head Start performance standards are considerably less prescriptive about the specific activities that programs should undertake. Thus, the Health Manager Survey and the interviews with health managers and staff devoted more attention to gathering information about the approach that programs take to informing and prioritizing the set of health-promotion activities to feature, the resources that programs rely on, and the approach to implementation. The monitoring and evaluation of these activities was another topic covered in the survey and interviews. This chapter first covers the array of health topics addressed with HS/EHS families and the health activities offered to HS/EHS staff. We then turn to approaches to planning for, implementing, and monitoring health-promotion activities.

Chapter Twelve Methods

- HS/EHS programs are the unit of analysis
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (modules 4 and 5) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups, defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.
- Insights from the interviews with health managers and other staff and open-ended survey responses are integrated where relevant.

Key findings related to *health-promotion topics* addressed with HS/EHS families include the following:

- Topics addressed by close to 90 percent of programs include nutrition or healthy eating practices, oral hygiene and physical activity, and fitness.
- While the topics addressed are similar in HS programs and EHS programs, a few topics were addressed about twice as often in EHS programs: family planning, prenatal health, breast-feeding/lactation, postpartum health and care, and caring for an infant.
- Staff-wellness activities are less common than the health-promotion activities available for families. However, at least one-half of all HS/EHS programs had staff-wellness initiatives related to injury prevention and safety, stress management, physical activity and fitness, and weight management or nutrition information.

With respect to *planning for health-promotion activities*, a number of key findings were identified:

- Health managers relied on a variety of sources to inform the choice of health promotion and prevention activities. Community or self-assessment data, program priority areas, and parent input were cited by about 70 percent of programs. Other input comes from OHS priorities, parent surveys, and HSAC feedback.
- The process of prioritizing and selecting health activities varied to some extent with health activities in the classroom, with parents in meetings and workshops, and with families in the home. Planning accounted for the underlying needs, as well as the availability of materials and their cost and cultural and linguistic match, the time to train and implement, and the context for delivery.
- Just over 80 percent of health managers reported looking for resources or curricula on the Head Start website. A majority of health managers also draw on recommendations from community partners or other health-related websites for information. Health managers are concerned, however, that the reading level of the educational materials available to them is often too high for the families they serve, and resources are not always available in languages other than English and Spanish.
- Few programs reported using evidence-based curricula to address health promotion. Instead, most cited use of stand-alone health resources or educational materials, although there is little overlap in use of these resources across programs, and the evidence behind these resources is not known.
- According to health manager reports, just under 50 percent of programs are using some or all parts of the *I Am Moving, I Am Learning* (IMIL) set of tools developed and supported by OHS. Of those programs not using IMIL, lack of staff training and not knowing about the program were most often cited as reasons.

Key findings related to the *implementation of health-promotion activities* included:

- Only 40 percent of health managers reported always selecting or adapting health-promotion materials to match the cultures and languages of the families served in the programs.
- Health managers noted the importance of teacher buy-in for successful implementation of classroom activities. Staff voiced a desire for more support and training to implement health-promotion activities.
- Parent engagement is also viewed by health managers as important, especially for activities in the home. Programs use multiple approaches to communicate with parents about health promotion, with 90 percent of programs reporting communication by newsletter.
- Programs also use a variety of incentives to encourage parent participation in health-promotion activities; the most common are serving food or snacks, offering child care, and offering door prizes.
- Communication between health managers and home-visiting staff is also critical, as is the need to balance health-promotion activities with the other objectives of home visits and related home-based activities.

- A number of barriers to implementing health-promotion activities were identified. About one-half of programs reported lack of parent or family interest, and lack of family time was also commonly cited.

Programs were also asked to report on how they *monitor health-promotion activities*. Key findings include the following:

- More than 80 percent of programs reported that regular monitoring of health-promotion activities takes place, although this is commonly limited to process metrics. About two-thirds of programs keep track of the number and types of health-promotion activities that they conduct, for example.
- One common set of outcome measures used for monitoring purposes is physical measurements (e.g., weight, BMI), used by 72 percent of programs.
- Far fewer reported that they monitor or evaluate the effectiveness of their health programming or health-promotion activities, citing a lack of time and expertise.

For survey topics included in the Health Manager Survey core, we were able to examine differences in results for Region XI and Region XII programs, as well as by health manager and program characteristics. Key findings related to these differences are summarized at the conclusion of the chapter.

Health Topics Addressed with Families and Staff

As part of the survey supplement, health managers were asked to indicate the health topics being addressed with families (and children) in their programs from a list of 22 specific topics, allowing for multiple topics to be selected. Table 12.1 shows the average number of topics selected and the percentage of programs covering each topic, for all HS/EHS programs combined and separately for HS programs and EHS programs.

On average, program health managers reported addressing 15 of the 22 topics (with a range from four to 23 topics, including "other"). With the exception of bed bugs and family planning, at least one-half of all HS/EHS programs were addressing the other 20 topics asked about in the survey. Topics addressed by programs almost universally include nutrition and/or healthy eating practices (91 percent), oral hygiene (89 percent), and physical activity and/or fitness (87 percent). Interestingly, these topics align with the two most prominent physical health issues mentioned by health managers for children in their HS/EHS programs: overweight and obesity and tooth decay or cavities (see Table 6.1). The former was also the priority health issue mentioned for adults in HS/EHS families (see Table 6.5).

Table 12.1. Health Topics Being Addressed with Families in the Program: By Program Type

Health Topics	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Health topics being addressed with families in the program			
Average number reported (*N*)	15.4	14.6	16.8
Percentage for each topic (%)			
Nutrition and/or healthy eating practices	91.3	91.3	91.4
Oral hygiene	89.1	88.5	90.0
Physical activity and/or fitness	87.0	88.0	85.2
Handwashing or hand hygiene	82.8	81.7	84.7
Injury prevention and safety (e.g., dog bites, motor vehicle safety/car accidents, food safety)	82.4	80.6	85.6
Importance of immunizations	80.4	79.6	81.7
Behavioral or mental health	78.3	77.0	80.6
Environmental health (pesticide, lead, secondhand smoke)	76.3	74.4	79.6
Head lice	72.1	73.7	69.3
Education on asthma triggers or prevention	65.5	66.4	64.0
Tobacco-use prevention or cessation	63.7	60.7	68.9
CPR or first aid	59.1	56.7	63.4
Importance of sleep or rest for children	55.7	55.4	56.1
Prenatal health	54.7	40.6	79.7
Sun safety and skin cancer prevention	53.7	49.9	60.4
Breast-feeding/lactation	53.6	39.7	78.4
Postpartum health and care (e.g., depression)	53.6	39.5	78.7
Violence prevention (e.g., bullying, fighting, partner violence)	52.7	52.6	52.8
Caring for an infant (e.g., diapering, bathing)	52.2	39.9	74.2
Alcohol or other drug use prevention or treatment	50.4	45.8	58.6
Bed bugs	39.0	35.6	44.8
Family planning	31.2	24.5	43.1
[Missing]	*6.9*	*7.5*	*6.0*
Number of health manager respondents	357	305	200
Number of programs	465	286	179

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: The list of topics has been reordered from most to least prevalent across all HS/EHS programs. Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

About 70 to 85 percent of programs addressed other topics, including (in descending order of prevalence): handwashing or hand hygiene, injury prevention and safety, importance of immunizations, behavior or mental health, environmental health, and head lice. A variety of other topics are somewhat less likely to be covered but are still made available in about one-half of all HS/EHS programs—specifically (again in descending order of prevalence): education on asthma triggers or prevention, tobacco-use prevention or cessation, CPR or first aid, importance of sleep or rest for children, prenatal health, sun safety and skin cancer prevention, breast-feeding/lactation, postpartum health and care, violence prevention, caring for an infant, and alcohol or other drug use prevention or treatment. For the most part, the incidence of offering each topic is very similar for HS programs and EHS programs. On average, EHS programs address two more topics than HS programs (17 versus 15 topics). The five topics that are a particular focus for EHS families—family planning, prenatal health, breast-feeding/lactation,

postpartum health and care, and caring for an infant—are offered at about twice the rate in EHS programs as they are in their HS program counterparts.

In light of evidence that HS/EHS staff have poorer physical and mental health when compared with population averages (Whitaker et al., 2013), health managers were also asked, as a supplemental question, to identify the wellness activities made available to HS/EHS staff in their programs, with nine types of activities listed. Table 12.2 shows the average number and prevalence of wellness activities across all HS/EHS programs and separately for HS programs and EHS programs.

Overall, staff-wellness activities are less common than the health-promotion activities available for HS/EHS families shown in Table 12.1. On average, health managers reported about three staff-wellness activities (ranging from zero to nine activities). The most common, available to staff in at least one-half of all HS/EHS programs overall, are injury prevention and safety (62 percent), stress management (60 percent), physical activity and fitness (53 percent), and weight management or nutrition information (52 percent). Physical health screenings are less common (43 percent), while offerings are even less frequent for asthma management (15 percent), oral health screenings (12 percent), and cancer screening (11 percent). The prevalence of each of these activities is very similar for HS programs and EHS programs.

Table 12.2. Wellness Activities Offered to Staff in the Program in the Past Year: By Program Type

Wellness Activities	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Wellness activities offered to staff members in the past year			
Average number reported (*N*)	3.2	3.2	3.3
Percentage for each activity (%)			
Injury prevention/safety	62.2	61.4	63.4
Stress management	60.4	58.6	63.7
Physical activity/fitness	52.9	50.6	57.0
Weight management, nutrition information	51.6	51.5	51.9
Physical health screenings	42.6	42.2	43.4
Tobacco cessation	23.0	23.7	21.6
Asthma management	14.8	14.9	14.8
Oral health screenings	12.1	12.1	12.2
Cancer screening	10.9	11.8	9.3
[Missing]	*9.2*	*8.1*	*11.2*
Number of health manager respondents	376	323	204
Number of programs	483	298	185

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: The activities have been reordered from most to least prevalent among all HS/EHS programs. Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Planning for Health-Promotion Activities

Planning for health-promotion activities requires identifying and prioritizing the most-relevant topics or activities to offer in a given HS/EHS program and identifying resources and curricula to support those activities. In this section, we draw on survey and interview data to examine the factors that inform the choice of health activities, the identification of curricula and other resources, and the curricula used by programs related to prevention and health promotion.

Informing the Choice of Health Activities

To learn more about how health managers determine the topics to cover as part of health-promotion activities, a survey question in the supplement asked health managers to identify the factors or sources of information that contribute to their choice of topics. Table 12.3 shows the prevalence for each of the 11 factors or sources of information listed on the survey, both for HS/EHS overall and separately by program type. Overall, it is clear that health managers are influenced by multiple factors and rely on a variety of sources, with an average of nearly seven sources selected (ranging from one to 12, including "other"), and with eight of the 11 items selected by at least one-half of all respondents. Most common is the use of community or self-assessment data, a resource employed in 72 percent of HS/EHS programs. Two other factors were cited almost as often: the program's priority areas (e.g., as identified by health screens and other information) (70 percent) and informal parent input (68 percent). Other important influences include observation of children (64 percent), HSAC recommendations (62 percent), OHS (i.e., national) priorities (58 percent), surveys with parents (58 percent), and observation of parents (54 percent). Factors that are less likely to play a role in determining the topics to target for health promotion include recommendations from community partners (47 percent) or the program director (38 percent) and local or state policy (32 percent). For the most part, these patterns are replicated for both HS programs and EHS programs.

Perspectives from Health Managers and Staff on Prioritization of Health Activities

During the interviews, HS/EHS health managers and staff provided additional information about the process for prioritizing and selecting health activities, drawing distinctions among the approaches used for health activities conducted with children in the classroom, with parents in meetings and workshops, and with families in the home.

Table 12.3. Factors or Information Contributing to Choice of Health Topics: By Program Type

Factors	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Factors or information contributing to choice of health topics as target of health promotion			
Average number reported (*N*)	6.8	6.7	7.0
Percentage for each factor/information (%)			
Community or self-assessment data	71.7	70.1	74.7
Informal parent input	68.3	67.5	69.8
HS/EHS program priority areas (e.g., identified through health screens)	70.0	66.2	76.7
Observation of children	63.5	62.7	65.0
Observation of parents	54.2	52.7	56.9
Surveys with parents	57.5	58.3	56.1
HSAC recommendations	62.1	61.3	63.7
HS/EHS director recommendation	38.0	36.8	40.2
Community partner organization recommendation	47.0	44.9	50.7
Local/state policy (e.g., health insurance, health impact assessment, zoning, economic)	32.2	30.8	34.6
OHS (national) priorities	58.0	57.4	59.1
[Missing]	*7.5*	*8.1*	*6.4*
Number of health manager respondents	357	305	200
Number of programs	465	286	179

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Prioritization of Health Activities in the Classroom

Health managers indicated that they look not only at the most-prevalent health concerns but also at trends over time (e.g., to identify troubling trajectories of health indicators in the community). Several went a step further to examine the geographic distribution of health concerns, noting those conditions that are especially prevalent in the counties where HS/EHS children and families reside, even if the prevalence for the larger region overall is lower.

> *What we do depends on problems we are seeing as a result of physicals. We focus a lot on oral health and nutrition due to needs and overweight and obesity. It's based on the needs that arise from physicals and screenings.* —Health manager

> *We use the annual community assessment and look for some sort of red flag. One zip code had the highest rate of childhood obesity, for example. In the community, we look at acute and chronic disease, including infectious disease outbreaks.*
> —Health manager

Health managers noted several practical considerations that often help to finalize their prioritization decisions, more than other such factors as whether there is an evidence base behind the selected resources or curricula. Cost, time, and the availability of materials or resources that can be used in the classroom and are culturally or linguistically appropriate are also factors that

guide decisions. Even if health concerns are considered high priority, they may be tabled if suitable resources or curriculum cannot be found.

> *Money is also a factor: If it costs a lot we can't always do it. We can't implement the way we like if we don't have a grant.* —Health manager

> *I think about how much effort and time it will take to implement. It's hard to do extra things when the main stuff never changes.* —Health manager

> *The evidence base does not factor in as much as it should, but cultural and linguistic appropriateness does.* —Health manager

Prioritization of Health Activities in Parent Meetings and Workshops

Although some programs noted that several of their health topics for regular parent meetings (e.g., monthly meetings held in the evenings or on the weekends) are required, most reported that the prioritization is largely based on responses from parent surveys. Both HS staff and EHS staff noted that parent involvement is notoriously challenging, but focusing on areas that parents request increases participation and buy-in. Although the health manager usually finalizes, or signs off on, the topics to be discussed in the meetings, staff members leading these meetings have the flexibility to present the topic in various forms.

> *During our monthly parents meetings, we ask the parents what they would like to learn for the month and we'll look for trends. But we also map the topics we discuss with parents to health issues related to the season. Sometimes the health manager tells us what we have to do—pedestrian safety, for example, is required. But for the most part, it's family driven.* —Family service worker

> *Our family and community partnership manager gives us a list of what topics we're supposed to cover every month. One month is safety, then child development, nutrition, literacy, etc. But we . . . have free rein within those topics to decide what to give to our parents.* —Family service worker

Prioritization of Health Activities in the Home

Health-promotion topics addressed during the home visit are driven primarily, if not exclusively, by parents. Home-visiting staff typically have parents fill out a sheet and circle areas of interest to them that they would like additional support on, and many of those topics are health related (e.g., fostering good toothbrushing skills, nutrition in the home). Although this parent-driven approach is viewed as beneficial in that the home visitors are meeting the individual needs and interests of families, the result is that health promotion in the home setting is not systematic or consistent across families. Home-visiting staff reported that most families are willing to accept help or guidance, particularly once they have built trust with the home visitor, but some families are not as receptive to discussing health-related concerns. As a result, the extent to which health-promotion activities are introduced with families during home visits varies.

> *We have parents fill out a parent interest sheet. We ask whether they want information about nutrition, meals, child height and weight, etc. We also have the*

parent chart for 24 hours what the child eats and drinks and that goes to the dietician, and the family gets feedback. —Home visitor

Identification of Resources

Health managers were also asked to indicate how they find resources or curricula to use once they have determined that a health topic needs to be addressed. The survey offered ten possible approaches, and Table 12.4 reports the prevalence of each across all HS/EHS programs and then by program type. Overall, health managers reported that they are making use of multiple approaches to finding resources, with an average of nearly seven strategies selected overall (the range is one to ten). Each of the ten approaches is employed by 47 percent or more of HS/EHS programs. The most-cited approach is use of the Head Start website (83 percent),[31] while other common resources include recommendations from a consulting provider or other community partners (73 percent), recommendations from the HSAC (70 percent), and prior use or familiarity with the curriculum (69 percent). Other prevalent approaches were searching the Internet (64 percent), child care and safety resources (63 percent), professional association websites or listservs (60 percent), and recommendations from state or local government (57 percent). Health managers were somewhat less likely to report using the technical assistance network for Head Start (51 percent) or recommendations from other HS/EHS programs (51 percent).

Comparing across program types, Table 12.4 shows few differences in the prevalence for each approach for HS programs versus EHS programs. Region XI AIAN programs show a lower incidence in the use of each approach (although their relative ordering is similar), suggesting that they are using fewer approaches overall. Region XII MSHS programs are closer to the national pattern.

When viewed by other program characteristics (see Table H.12.4 in Appendix H), several interesting differences emerge. For example, programs where health managers have health-related bachelor's degrees are more likely to rely on prior use or familiarity with the curriculum, compared with health managers with no health-related degrees (71 percent versus 55 percent). The group with the degree background is also more likely to rely on professional association websites and listservs (63 percent versus 43 percent). Medium and larger programs are more likely to rely on recommendations of the HSAC, compared with smaller programs (73 percent versus 65 percent). Finally, compared with programs in more-rural areas, programs in more-urban areas were more likely to report using recommendations of other HS/EHS programs (51 percent versus 41 percent), professional associations (59 percent versus 51 percent), and recommendations from state and local government (57 percent versus 51 percent).

[31] Although the survey question referred to the Head Start website more generally, this resource includes the ECLKC.

Table 12.4. Approaches Used to Find Health Topic Resources or Curricula: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
How health managers find possible resources or curricula for a health topic that needs to be addressed					
Average number reported (*N*)	6.5	6.4	6.7	5.8	6.4
Percentage for each resource (%)					
Prior use/familiarity with the curriculum	68.5	65.9	73.0	65.6	62.7
Recommendation from other HS/EHS programs	50.5	49.9	51.7	41.7	46.3
Recommendation from HSAC	70.4	69.3	72.2	63.9	71.6
Recommendation from consulting provider or other community partners	73.0	72.6	73.7	66.4	70.8
Head Start website	83.3	82.0	85.5	74.6	76.9
Technical assistance network for HS/EHS	51.3	49.5	54.4	45.9	56.9
Child care health and safety resources	63.4	62.6	64.8	55.8	63.1
Professional association websites or listservs	59.5	56.5	65.0	46.6	62.3
Recommendation from state or local government	56.8	56.2	57.8	47.7	69.8
General Internet search	63.8	63.8	63.8	62.5	60.2
[Missing]	*6.7*	*6.4*	*7.2*	*13.8*	*9.2*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Additional Perspectives from Health Managers on the Identification of Resources

In the interviews, health managers expanded on the identification of resources. Consistent with Table 12.4, many health managers reported utilizing Head Start–related sources. Although health managers find these resources helpful, several noted that materials are commonly not available in other languages, or were written at a reading level that is too high for the families they serve.

> *Usually I look at ECLKC first and make sure that [the resource] is Head Start approved. I can find a lot of basic things from there. You know that the information meets Head Start standards.* —Health manager

> *[I use] ECLKC because, as of recently, there are new materials on health literacy, oral health, and family-style meals. There is a plethora of information, and I go there especially because we are Head Start.* —Health manager

Health managers face similar challenges with materials and resources obtained through community providers and their HSACs, in that the resources typically are only offered in English, and the literacy burden of the materials is often too high.

> *We contact our health department partners, but again the materials are a higher [reading] level. We still hand out the brochures, but we have to frame it out.* —Health manager

Finally, health managers use other health managers as an important resource and source of health-related information. Several pointed to the value of state listservs for health managers as a way to share information. Others meet in person with health managers in their geographic areas. Although results from our survey suggest that not all health managers are well connected to other health managers (see Table 4.10), those who are linked noted that these connections have been quite helpful for learning how others have addressed specific health-related topics and for identifying resources that other programs have found helpful.

> *I talk to other health mangers in the field. It's important to find people that do what you do and get a sense of what is and is not working. It has helped me identify curriculums and strategies.* —Health manager

HS/EHS staff, including teachers, family service workers, and home visitors, reported that they occasionally turn to web-based sources on their own to learn more about specific topics, although most reported that the information and resources that they use are primarily obtained from their health managers. The vast majority of staff respondents noted that their health managers are very responsive to requests and provide information and resources to help staff address any unique health-related needs that arise in the classroom or in the home.

Curricula Used for Health Topics and Health Activities

To delve more into the specific prevention and health-promotion curricula in use, health managers were asked, in an open-ended item, to list the health curricula (defined by the respondent) currently being used in their programs. Out of more than 1,000 entries, we identified a list of 22 entries that were mentioned by at least ten health managers. Upon closer inspection, we determined that a number of the 22 entries would not meet the definition of a curriculum, in terms of having lesson plans with sequenced learning objectives, stated outcomes desired for participants, training materials for educators, and (ideally) research-based evidence of effectiveness. Table 12.5 presents the list of 22 responses, eight of which we classify as health-related curricula (panel A) and the remaining 14 as other types of resources (panel B). For each entry, we identify the publisher (or creator), the health areas targeted by the curricula and resources, and whether or not the curricula or resource were listed on the Head Start National Center on Health website as of December 2014. The eight curricula listed in panel A clearly cover a range of health-related topics; however, not all have a rigorous evidence base, and just three of the eight are listed on the Head Start National Center on Health website as a recommended or referenced resource. The other resources listed in panel B also cover a range of health areas and only three were referenced on the National Health Center website.

Table 12.5. Health Curricula and Other Resources Named by Health Managers

Name	Publisher	Health Area Targeted	On Head Start National Center on Health Website[a]
	A. Curricula		
Bright Smiles, Bright Futures	Colgate	Oral health	Yes
Cavity Free Kids	Washington Dental Service Foundation	Oral health	Yes
Color Me Healthy	NC Cooperative Extension; NC Division of Public Health	Obesity prevention	No
Growing, Growing Strong	Healthy Childcare Consultants	Health and wellness	No
Partners for a Healthy Baby	Florida State University	Health and wellness	Yes
Second Step	Committee for Children	Social-emotional skills	No
SPARK: Sports, Play, and Active Recreation for Kids	SPARK	Obesity prevention	No
Talking About Touching	Committee for Children	Personal safety	No
	B. Resources		
5-2-1-0	Let's Go! Standards adopted from Nutrition and Physical Activity Self-Assessment for Child Care	Obesity prevention	No
Bright Futures	HRSA Maternal and Child Health Bureau and American Academy of Pediatrics	Health and wellness	Yes
Chef Combo	National Dairy Council	Obesity prevention/nutrition	No
Conscious Discipline	Conscious Discipline	Behavior	No
Cooking Matters	No Kid Hungry	Obesity prevention/nutrition	No
Eat Well Play Hard	New York State Department of Health	Obesity prevention	No
Food Friends	Colorado State University	Obesity prevention	No
Hip on Health	Healthy Childcare Consultants	Health and safety	No
I Am Moving, I Am Learning	Office of Head Start	Obesity prevention	Yes
I CAN	Central Missouri Community Action Head Start and UCLA Johnson & Johnson Health Care Institute	Health and wellness	No
Let's Move	Michelle Obama's Initiative	Obesity prevention	Yes
Little Voices for Healthy Choices	Office of Head Start	Health and wellness	Yes
MyPlate	U.S. Department of Agriculture	Obesity prevention	Yes
What to Do Books	UCLA, Johnson & Johnson	Health and wellness	No

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey, and Internet searches regarding the curricula.
NOTES: Includes all curricula and resources named by ten health manager respondents or more. NC = North Carolina; HRSA = Health Resources and Services Administration.
[a] As of December 2014. Note that the website for the Head Start National Center on Health became active in August 2013, so it was not available to health managers during much of the period covered by the Health Manager Survey (December 2012 to November 2013**).**

Table 12.6 reports the proportion of HS/EHS programs that reported using each of the eight curricula and the other 14 resources listed in Table 12.5, with separate results for HS programs and EHS programs, and for all programs in Region XI and in Region XII. In reviewing these results, it is important to keep in mind that health managers were not shown a list of curricula or resources and asked to mark those in use. So it is possible that, if prompted, some additional programs would report using these materials. For this reason, the percentages in Table 12.6 may be viewed as conservative estimates.

Table 12.6. Health Curricula and Resources Used: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Health curricula and resources used (%; more than one may apply)					
Curricula					
Bright Smiles, Bright Futures	24.2	25.2	22.4	30.0	22.5
Cavity Free Kids	9.5	9.8	8.9	4.2	21.0
Color Me Healthy	4.6	4.9	4.0	4.4	2.6
Growing, Growing Strong	1.1	1.0	1.1	0.0	0.0
Partners for a Healthy Baby	5.9	2.9	11.4	1.5	9.7
Second Step	4.7	5.2	3.9	5.7	0.0
SPARK	1.6	2.0	1.0	3.4	0.0
Talking About Touching	1.1	1.2	0.9	3.0	0.0
Resources					
5-2-1-0	1.2	1.1	1.2	0.4	3.3
Bright Futures	1.4	1.0	2.2	0.0	0.0
Chef Combo	1.6	1.9	1.1	1.3	0.0
Cooking Matters	0.8	0.8	0.9	0.0	0.0
Conscious Discipline	1.3	1.4	1.2	0.0	0.0
Eat Well Play Hard	1.5	1.9	0.9	0.0	1.9
Food Friends	0.7	1.0	0.2	0.0	1.8
Hip on Health	1.1	1.1	1.1	0.0	0.0
IMIL	46.8	48.9	43.2	42.9	50.4
I CAN	1.2	1.2	1.4	0.0	6.2
Let's Move	1.0	0.9	1.2	0.0	3.8
Little Voices for Healthy Choices	1.3	0.8	2.1	1.2	3.5
MyPlate	3.6	3.6	3.5	1.3	6.7
What to Do Books	5.6	4.9	6.8	3.0	2.7
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases.

IMIL—an obesity-prevention approach developed in the Region III Office of the Administration for Children and Families (2006), under the leadership of Amy Requa and Linda Carson—stands out among all of the entries in Table 12.6 for having the highest frequency of use (47 percent of programs). The next most common is Bright Smiles, Bright Futures, an oral health curriculum developed by Colgate, which was mentioned by 24 percent of programs. Another oral health curriculum, Cavity Free Kids developed by Washington Dental Service Foundation, is used by about 10 percent of programs. Reported use of the six other curricula all

fall below 10 percent of programs. With few exceptions, the other 13 resources, other than IMIL, are used by no more than 5 percent of programs. For the top three curricula or resources in use, the patterns are very similar for HS programs and EHS programs. For EHS programs, Partners for a Healthy Baby developed by Florida State University is used by about 11 percent of programs, considerably higher that the usage rate in Head Start, which is consistent with the differences in the age groups served. Compared with the national rates, Region XI AIAN programs are somewhat more likely to use Bright Smiles, Bright Futures (30 percent). Region XII MSHS programs reported using Cavity Free Kids at about twice the national rate (21 percent).

Given the investment on the part of OHS in developing and disseminating IMIL, the Health Manager Survey asked a supplemental follow-up question of those respondents who did not list IMIL among the resources in use. Table 12.7 shows the distribution of responses among the set of respondents eligible for the supplemental question, which is a relatively small sample. Overall, nearly two reasons were selected on average (ranging from one to six), but about 30 percent selected no explanation. Of the explanations listed, the most frequent explanation selected was that staff have not been trained on IMIL (19 percent), followed by 11 percent who stated that they had never heard of the program. A similar percentage stated that they have no plans to use IMIL in the immediate future. Given that IMIL was originally targeted to children ages three to five, it is not surprising that health managers in EHS programs were more likely to state that they have never heard of the resource.

Additional Perspectives from Health Managers on Curricula Used for Health Topics and Health Activities

The use of IMIL was discussed during several interviews, and health managers noted some of the challenges that arise in using resources more generally. Health managers noted that they might attend a train-the-trainer session for a resource such as IMIL or another curriculum, but they also find it helpful when a trainer comes directly to the program to train the staff. In some cases, the health manager would have preferred to send staff to an external training, but resources were not available. Moreover, with staff turnover, training is an ongoing need, rather than a one-time event. Health managers also noted that resources, like IMIL, might have to be adapted to their settings to be most useful. IMIL was also cited as an example of a resource that did not go far enough in helping teachers with using the content throughout the day. These comments suggested that there might be variability in the training that staff have regarding the use of a particular curriculum or resource and in the fidelity of implementation.

> *I just finished an IMIL train-the-trainer session and hope to be able to train all of our teachers in IMIL. Teachers and managers have had some pieces of IMIL, but having someone be able to be the trainer will put emphasis on this topic. —*
> Health manager

The most challenging piece is that [teachers] don't understand how to extend IMIL throughout the day. It is hard especially with other demands. They are doing it intentionally, but not at the level as it was originally intended. —Health manager

Table 12.7. Reasons Providers Are Not Using IMIL: By Program Type PRG04a

Reason	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Among those not using IMIL, reasons not using			
Average number of regions (*N*)	1.6	1.6	1.5
Percentage for each reason (%)			
I have never heard of the program	10.8	8.0	15.5
The training that was provided was not sufficient for implementation; more training is needed	4.1	4.1	4.0
Guides for how to train staff are needed	2.5	2.5	2.5
Staff have not been trained on IMIL	18.6	17.6	20.2
Not enough time to implement it	5.4	4.9	6.3
Not enough resources to implement it	4.9	4.9	4.9
Children or parents do not like it	2.2	1.4	3.5
Staff do not like it	2.1	2.6	1.3
Program administrators are currently not interested in using it	2.2	1.8	2.8
We are unable to adapt it to meet the language and cultural needs of our children and families	0.9	1.5	0.0
We found another obesity-prevention curriculum that we like better	6.9	8.4	4.4
We used IMIL in the past but are not using it now	6.5	6.3	6.8
We are not using IMIL now, but plan to do so in the next year	8.3	6.9	10.5
We have no plans for using IMIL right now	10.8	11.6	9.4
Other	27.0	29.5	22.9
No option selected	30.4	32.0	27.8
Number of health manager respondents	172	134	94
Number of programs	212	127	85

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding

Implementing Health-Promotion Activities

Several questions in the supplement to the Health Manager Survey asked about approaches health managers use in implementing health-promotion activities; the results are reported in Table 12.8 for all HS/EHS programs and by program type. First, health managers were asked about the extent to which health-promotion materials are selected or adapted to match the cultures and languages of the families served. The response categories included "never," "rarely," "sometimes," "often," and "always." As seen in the first entry in Table 12.8, health managers in 40 percent of HS/EHS programs overall responded that they always select or adapt materials to match the cultures and languages of the families they serve. Another 35 percent responded that they often take this approach, and 22 percent stated that they do so sometimes. Just 3 percent indicated that they rarely select or adapt materials for this purpose, and no

respondents indicated "never." The distribution of responses to this question is very similar for HS programs and EHS programs.

A second question, reported in the second entry of Table 12.8 for all HS/EHS programs and by program type, asked health managers about the methods used most often to share health-promotion information with HS/EHS families. Six options were specified in the questionnaire, and about three methods were selected on average (ranging from one to six methods). Overall, the most common method is the use of written materials, such as newsletters, selected by health managers in 90 percent of programs. Multiple in-person training sessions is another method used by 56 percent of programs, followed by one-time, in-person sessions used by 45 percent of programs. Other methods that are less likely to be used include phone-based sessions (32 percent); electronic communications, such as email or web-based information (24 percent); and parent-to-parent interaction (21 percent). These rates are very similar when HS programs and EHS programs are examined separately.

A final implementation question inquired about methods used to encourage parents or guardians to take part in health-related activities or events. Five options were included in the survey, with results shown in the third entry in Table 12.8. With all but one method used by a majority of health managers, it is clear that multiple approaches are being used. Indeed, an average of three methods were selected (ranging from one to six, including "other"). Most common is serving food, such as snacks or dinner, an approach used by 78 percent of programs. Provision of child care was indicated by health mangers in 65 percent of programs, while offering incentives, such as door prizes or sample products, was selected for 62 percent of programs. Programs are somewhat less likely to encourage parent participation by providing interpreters (50 percent) or transportation (44 percent). There is very little difference between HS programs and EHS programs in their use of these different approaches.

Health managers were also asked to identify the biggest challenges with implementing health-promotion activities in their programs. Fifteen different possible challenges were listed, with results tallied in Table 12.9 for all HS/EHS programs and by program type. The issues included constraints on the part of the HS/EHS program in terms of various supports, constraints on the part of families, the quality of the health-promotion materials, and cultural or linguistic barriers. Overall, health managers reported an average of just over three barriers (ranging from one to 14 barriers). As with other questions related to barriers, the dominant challenge selected by health managers, in 58 percent of programs, is a lack of parent or family interest or support for the topic. Other factors commonly cited are a lack of parent or family time to engage in the activity (49 percent) and limited time to implement the activity (48 percent). There is some support for other constraints at the program level, such as not enough time to provide staff training (42 percent), competing program priorities and therefore not enough resources or funds (37 percent), and lack of staff buy-in (36 percent). Limited parent literacy was indicated in a minority of programs (19 percent). Issues with the quality of the health-promotion materials or

trainings or cultural or linguistic barriers were selected in just 3 to 13 percent of programs. Lack of support from the HSAC or director was rarely cited as major challenges (4 to 5 percent).

Table 12.8. Approaches to Implementation of Health-Promotion Activities: By Program Type

Factors	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Extent to which health materials are selected or adapted to match the cultures and languages of the families served (% distribution)			
Never	0.0	0.0	0.0
Rarely	2.6	2.9	2.0
Sometimes	22.3	24.0	19.4
Often	35.1	35.0	35.3
Always	40.0	38.2	43.3
[Missing]	*9.6*	*9.7*	*9.4*
Methods used most often to share health-promotion information with the families served			
Average number reported (*N*)	3.4	3.4	3.4
Percentage for each method (%)			
Written materials (e.g., newsletters)	89.5	89.4	89.6
A one-time, in-person session	45.0	44.5	45.9
Multiple in-person training sessions	56.0	56.1	55.9
Parent to parent	21.3	22.1	19.9
Phone-based sessions	31.9	32.8	30.2
Electronically (e.g., email, web-based information)	24.2	25.7	21.6
[Missing]	*11.2*	*11.2*	*11.0*
Methods used to encourage parents/guardians to take part in health-related activities or events			
Average number reported (*N*)	3.1	3.1	3.0
Percentage for each method (%)			
Offer incentives, such as door prizes or samples of products	62.3	63.1	61.1
Provide transportation	44.0	43.9	44.3
Provide child care	65.0	66.0	63.1
Provide interpreters	50.2	48.6	52.9
Serve food, such as snacks or dinner/supper	77.9	78.6	76.7
[Missing]	*11.2*	*11.2*	*11.0*
Number of health manager respondents	357	305	200
Number of programs	465	286	179

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages and percentage distributions are computed for nonmissing cases, and percentage distributions might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

When viewed from the perspective of HS programs or EHS programs, these challenges were selected at similar rates. The same is true for Region XI AIAN programs. Region XII MSHS programs were less likely to mention a lack of parent or family interest (40 percent); instead, the dominant challenge is limited time for implementation (69 percent). Competing program priorities and limited resources was another factor given more weight in Region XII programs (52 percent). When differences are viewed based on other program characteristics (see Table H.12.8 in Appendix H), a few patterns stand out. Health managers with health-related bachelor's

degrees were more likely to mention limited time as a barrier, compared with those with no such background (50 percent versus 42 percent). They were also more likely to mention low parent literacy (22 percent versus 13 percent). Low parent literacy was also selected at a higher rate by health managers in programs in mostly urban areas, compared with mostly rural ones (23 percent versus 12 percent). Those in rural areas placed more weight on a lack of parent or family interest (66 percent versus 54 percent). Finally, health managers in larger programs were more likely to mention a lack of staff buy-in than those in smaller programs (41 percent versus 29 percent).

Table 12.9. Challenges with Implementing Health Promotion Activities: By Program Type

Measure	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Biggest challenges to starting health-promotion activities in the program					
Average number reported (*N*)	3.5	3.4	3.5	3.3	4.0
Percentage for each challenge (%)					
Lack of support from the HSAC	3.7	3.6	3.8	3.2	9.9
Lack of support from the director	5.3	5.1	5.6	4.8	5.0
Lack of staff buy-in	35.8	35.3	36.9	30.0	39.7
Not enough time to provide training to staff	42.4	41.4	44.1	40.8	48.5
Lack of parent or family interest/ support in the topic	57.8	59.2	55.2	65.2	40.3
Limited time to implement	47.5	47.6	47.4	46.8	69.3
Lack of parent or family time to engage in the activity or the timing of the activity	49.0	49.4	48.2	48.5	44.8
Poor quality of the health-promotion curriculum or program to address the health topic	4.5	4.5	4.7	8.1	7.9
Poor quality of the health-promotion trainers	2.9	2.7	3.3	4.9	7.9
Not having enough staff who speak the language of the families we serve	6.2	6.3	5.9	3.5	5.0
Not having enough staff who come from the cultural backgrounds of the families we serve	3.5	3.5	3.6	1.9	3.2
Not having enough health materials in the languages of the families we serve	13.0	12.6	13.6	12.0	10.5
Not having enough health materials that are culturally appropriate for all families	12.4	11.7	13.8	13.5	14.5
Limited parent literacy	19.4	18.1	21.8	13.8	24.3
Competing program priorities/not enough resources or funds	36.8	35.8	38.6	28.5	51.9
[Missing]	*10.6*	*10.2*	*11.4*	*16.5*	*15.2*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Additional Perspectives from Health Managers and Staff on Implementation

Our interviews with health managers and other staff touched on implementation issues in the context of classrooms activities and when working with families and children in the home. We discuss each of these topics in turn.

Implementation in the Classroom

As part of the interviews, health managers discussed the importance of teacher buy-in and support to guide implementation. They noted that it is critical to allow teachers the flexibility to build the topic into their lesson plans as they see fit. However, health managers noted that this can be challenging if staff do not see the value of health-promotion activities or feel that this is "just one more thing we keep piling on them."

> *The outcome depends on teacher buy-in. If they are not real gung-ho about it, it won't happen. They won't reinforce it. I have a few teachers who are really excited about health, but others are less focused because they are so burdened. They have so many other responsibilities to address—they feel it is a waste of time; it feels like another burden.* —Health manager

> *Absolute buy-in is key. You have to do this at the center level. Teachers have to understand what you want to do and why you want to do it. You have to do some good foundation-laying work. Don't say, "Here is another curriculum, do this." You have to get their ideas.* —Health manager

Teachers also discussed the give and take between health managers and classroom staff. While health managers provide information and training to the teachers on the topics that should be covered and offer guidelines on the frequency with which health activities should be conducted (e.g., daily, weekly), teachers, for the most part, have flexibility in how the topics are introduced and enforced within their classrooms. With the exception of a very limited number of standardized health curricula (see Table 12.5), teachers utilize songs, science experiments, outside visitors, field trips, and a range of other activities to teach these topics to the children. Several teachers noted that they used the seasons to demonstrate lessons about health, wellness, or hygiene. For example, during winter seasons, teachers instruct children on the "bat wing" to ensure coughing into the arm and not the hand. During Halloween, teachers focus on pedestrian safety and oral health (good brushing after candy consumption). Water and sun safety are a focus for summer time. Other staff reported that their programs engage in toothbrushing during the class day to ensure that children knew the value of taking care of one's teeth.

Aside from these general public health and wellness topics, some programs include lessons regarding social and emotional competence. Staff reported that there are fewer options for such lessons and materials, but some programs had identified good resources (CDs, etc.) that explained ways in which children could integrate healthy coping behaviors when "they are mad or sad," for example. Staff members indicated that they want more support and training to expand these social-emotional offerings.

HS/EHS staff also shared that parents receive additional health information on a range of health topics through the resources or activities that teachers send home with the children. These materials can reinforce classroom learning.

> *Teachers have to do an activity every week. They put that on the lesson plan. Supervisors will monitor that, and if they did not do it, the supervisor will follow up and make sure it gets implemented.* —Health manager

> *Everything that happens in the classroom I decide with my co-teacher. We all have a list of unit topics that we all do and, at some point in time, each classroom is going to hit on these main topics. But we pick when and how we implement [them].* —Teacher

> *We have topics like mental health, anger and anxiety, safety, dental, health, and nutrition. We have activities around each of these at least once a month, though some are weekly and some are daily, like teeth brushing and hand washing. These are on our lesson plans.* —Teacher

Implementation with Families and in the Home

Most HS/EHS health managers interviewed highlighted the need to consistently engage parents and families in health-promotion activities. The rationale is twofold. First, such engagement is considered critical for reinforcing positive health behaviors at home. Second, parents and other family members possess their own health challenges, which could influence child health outcomes.

Given health concerns around overweight and obesity, several staff noted that parents particularly enjoy cooking classes and skill building around creating healthy meals. This education continues through to the home visits, where staff shared that they can review the types of food available to children in the home and discuss how a family can stay on budget while purchasing healthy foods.

The extent to which health-promotion activities are being implemented in the home varies across programs and appears to be driven by program priorities and objectives for the home visit, rather than the preferences of the home-visiting staff. While some staff interviewed felt that the home visit is an ideal time to work with families on a range of health-promotion activities that benefit the entire family, others are more focused on social service needs, child development, and school readiness goals and spend comparatively little time addressing health. To address this gap, a limited number of health managers—the majority of whom were new to their positions—reported that they recently changed their program policies or procedures in different ways to strengthen the delivery of health activities in the home. Examples include changes in staffing models where home visitors reported to having a direct line of communication with the health manager; offering home visitors the same health-related training that teachers and other staff receive; and revising the objectives of the home visits to include health as an explicit priority, rather than something to be addressed only if raised by the family.

Overall our goal is family support. We divide up the time, some of which is spent on an activity that the parents want to do with the child. The other half is some sort of educational piece. They choose what they want to be learning about, so we come prepared to discuss it. We bring handouts. —Home visitor

We have a monthly message, like the importance of sunscreen in the summer, but in the home we don't do a lot of health education. More as a whole we are talking about education, development, and health. —Home visitor

Communication between health managers and home-vising staff appears to be strong, as all participants noted that health managers work collaboratively with the home visitors to identify resources, information, and activities that the home visitor can use to address a family's needs. In some cases, health managers will accompany the home visitor to the home when there is a particularly sensitive or challenging health concern.

We offer modules that are health-related that family advocates can use in the home with the pregnant mom. [The topics] can range from postpartum depression, to substance abuse, to fetal-alcohol syndrome—anything that affects the fetus while developing. —Health manager

For families that aren't so receptive, it is hard to get information across to them. A lot of subjects are very touchy. We ask for help from health advisers, and we set up one-on-one meetings with them. —Home visitor

Monitoring Health-Promotion Activities

A final set of questions in the Health Manager Survey supplement concern the monitoring and assessment of health-promotion activities offered to children and families (Table 12.10). Note that here we are reporting on how programs monitor and assess the effectiveness of their health-promotion activities, which is different from tracking the screenings, health visits, and follow-up services of individual children, which was reported in Chapter Seven. For programming targeted at children and at families, health managers in the vast majority of programs (89 percent and 82 percent, respectively) indicated that regular monitoring of health-promotion activities takes place. These rates are very similar for both HS programs and EHS programs.

Table 12.10 also shows the percentage of programs using a given type of information to track the implementation and effectiveness of health-promotion activities. On average, programs reported using about three information sources (a range from one to seven). Of the seven types of information listed, the most common information used was physical measurements (e.g., height, weight, BMI), used by 72 percent of programs. About two-thirds (64 percent) reported tracking the number and type of health-promotion activities. Other information used by a majority of programs include classroom or home-visit monitoring of activities (56 percent) and surveys with parents or families about their responses to the activity or the changes in their health knowledge or behavior (55 percent). Programs are somewhat less likely to use information from home visitors (43 percent), while use of child surveys to capture feedback on the activity or changes in health knowledge is even less frequent (13 percent). With one exception, these patterns are very

similar for HS programs and EHS programs. EHS programs are more likely than HS programs to say that they use home-visitor information (54 percent versus 38 percent), a pattern that seems to reflect the fact that EHS programs are more likely to be home based than most HS programs, which are primarily center based.

Table 12.10. Approaches to Monitoring Health Promotion Activities: By Program Type

Factors	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Program regularly monitors the health-promotion activities (e.g., education, curricula) offered to children (% distribution)			
Yes	88.6	89.9	86.3
No	11.4	10.1	13.7
[Missing]	*10.6*	*11.2*	*9.4*
Program regularly monitors the health-promotion activities (e.g., education, curricula) offered to families (% distribution)			
Yes	82.3	84.6	78.4
No	17.7	15.4	21.6
[Missing]	*10.7*	*11.4*	*9.4*
Information used to keep track of how health-promotion activities are going			
Average number reported (*N*)	3.3	3.3	3.3
Percentage for each source (%)			
Tracking data on number and type of health-promotion activities	63.8	64.5	62.5
Surveys with children about their responses to the activity, change in health knowledge	12.8	13.0	12.5
Surveys with parents/families about their response to the activity, change in health knowledge or behavior	54.8	55.5	53.6
Surveys with staff about activity rollout, impact on children	19.9	19.7	20.3
Home-visitor information about how families are using the health-promotion activity/information	43.2	37.6	53.6
Classroom/home-visit monitoring of activities	56.2	58.0	53.0
Physical measurements (e.g., height, weight, BMI)	72.2	73.2	70.4
Number of health manager respondents	357	305	200
Number of programs	465	286	179

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Additional Perspectives on Monitoring

The vast majority of health managers reported that while they may monitor the activities that take place, they do not regularly monitor or evaluate the effectiveness of their health programming or health-promotion activities. Those who do were not confident in their ability to collect relevant information. Most health mangers noted that even though they would really like to collect such data, they simply do not have time.

It would be helpful to have information on how to evaluate our health programs. We go at it blindly regarding what to collect and how to collect it. There really isn't any guidance for us right now on how to do this. —Health manager

I don't think we are doing a good job of [evaluation.] We provide [programming], but we don't track it; we don't check in at regular intervals. —Health manager

I need to figure out how to get out from behind a computer to fill out forms and fill out compliance. But that is such an overwhelming amount of work. I spend the vast majority of my time managing data. —Health manager

Summary of Chapter Findings

Health managers address a wide range of health-promotion topics with the children, parents, and staff in their programs. Given that health managers reported overweight and obesity as a health-related concern for children and families in their programs, it is not surprising that nutrition and physical activity are two of the top three health-promotion topics addressed. HS programs and EHS programs address similar topics, although there is a heavier emphasis in EHS programs on health-promotion topics associated with pregnancy, postpartum care, and infancy. Although programs do offer staff-wellness activities, these offerings are not universal. Given that Head Start aims to have members of the local community or current or former HS/EHS parents as program staff members, and many staff may therefore share the health needs of current families, this could be an area deserving of additional attention.

Health managers reported using a variety of resources to inform their choices of the health topics to pursue and that the strategies for prioritizing across options differ for activities in the classroom, for those in parent workshops, and for those in the home. Likewise, varied sources are used to identify specific resources or curricula in support of the topics of interest. While there are few differences in the resources used across HS and EHS programs or for Region XI and Region XII programs, we did identify some differences based on the health manager's background, program size, and urbanicity. These differences suggest that health managers with a stronger health-related education background and those in larger programs and in mostly urban areas are using a more varied set of resources. Whether or not this leads to greater success was not ascertained as part of the study.

In support of health-promotion activities, health managers reported using a number of approaches to encourage parental engagement. About three-quarters of programs reported always or often selecting or adapting health-related information to meet the linguistic and cultural needs of the families they serve. Health managers did report the lack of materials in languages other than English and Spanish to be a barrier to implementing health-promotion activities. Another barrier noted by health managers is that they have limited time to implement health-promotion activities. This is consistent with findings from other parts of the survey, which suggest that health managers spend so much time meeting basic requirements that they do not feel that they have time to address other health issues, such as health-promotion activities, that they believe

would be more impactful. Although lack of family interest and lack of family time were also listed as a barrier to implementation of health-promotion activities, in Region XII, lack of family interest was not as big of a challenge, but having limited time to implement activities and competing priorities were mentioned more often. We also identified other differences in the prevalence of certain barriers based on the health manager's background, program size, and program rural-urban status. For example, health managers with health-related bachelor's degrees were more likely to cite limited staff time and low parent literacy. Among programs in more-rural areas, a more common barrier was a lack of parent or family interest. Health managers in larger programs were more likely to mention a lack of staff buy-in.

While programs did report tracking health-promotion activities, most of these activities are either process based (e.g., we track what activities we do) or fall under metrics that the program is already collecting (e.g., weight and height of children). Few programs are proactively collecting additional outcome information specific to the health-promotion topics being implemented. Health managers noted that this was driven by both a lack of time and a lack of knowledge of how to assess or evaluate health-promotion activities.

13. Community Partnerships in the Head Start Health Services Area

The role of community partnerships was discussed in the context of physical health services (Chapter Nine), behavioral and mental health services (Chapter Ten), and oral health services (Chapter Eleven). It is evident from the results presented in those chapters that HS/EHS programs work with a diverse array of organizations, that the nature of the relationships are varied, and that there are sometimes gaps in the ability of partner organizations to meet the health-related needs of HS/EHS children and families.

As part of the Health Manager Survey (module 6), we took a broader perspective to learn about these partnerships more generally. The aim was to understand the complete set of potential agencies and community-based organizations that work with HS/EHS programs, the contributions those community partners make to the health services area, the gaps that HS/EHS programs identify with their existing relationships, and the challenges that arise in meeting the health needs of the children and families served by Head Start. We discuss each of these issues in the sections that follow.

Chapter Thirteen Methods

- HS/EHS programs are the unit of analysis.
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Core questions in the Health Manager Survey (module 6) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups, defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.
- Insights from the interviews with health managers and other staff and open-ended survey responses are integrated where relevant.

Findings related to community partnerships covered contributions that organizations bring to Head Start, gaps in current partnerships, and challenges in meeting health needs. Key findings around *partners and their contributions* include the following:

- Health managers reported working with a wide range of community partners, the two most common partners being food and nutrition agencies and local health departments or public health departments.
- The HS/EHS programs that reported working with community partners receive health services, health education, and referrals, sometimes as paid services but frequently as unpaid or donated supports.
- The extent to which community partners are culturally responsive to the diverse families served by HS/EHS programs varies. Some programs feel that the majority of their

community partners do well in this regard, while about one-quarter feel that fewer than half of their partners meet this objective.
- Though partnerships are valuable to programs, they require a significant amount of time to cultivate and foster.

Key findings related to *gaps in partnerships and unmet* need included:

- Weight-control services was most often reported as the health need that requires additional partnerships (36 percent).
- About one-quarter of programs also reported gaps in community partners to address smoking cessation, alcohol and substance abuse, environmental health concerns, oral health care, and behavioral health care.
- Health managers reported a desire for key new partnerships with specific organizations. Those most often cited include legal aid, family financial planning, job service agencies, and college or university partnerships.

The following key findings relate to *challenges working with partners* to meet the health needs of children and families:

- When asked about barriers to providing health services, fewer than 10 percent of health managers reported that establishing linkages or partnerships with other organizations is extremely difficult.
- Information sharing across agencies while providing joint services is also not considered a barrier.
- Health managers did report challenges with obtaining timely evaluations of children living with disabilities and obtaining enough resources to meet the health needs of children who do not quality for IDEA Part B or Part C assistance.

Where they could be explored, any differences in these key findings for programs in Region XI and Region XII programs, as well as important differences by health manager and program characteristics, are summarized at the conclusion of the chapter.

Agency and Organization Partners and Their Contributions

Health managers were asked to identify, as part of a supplemental question, the specific types of agencies and organizations that they normally work with to address or support the health needs of children and families. Table 13.1 lists the 18 types of organizations included in the survey and the percentage of programs that work with each, both for all HS/EHS programs combined and separately for HS programs and EHS programs. Overall, consistent with results in earlier chapters, it is evident that HS/EHS programs engage with a multiplicity of agencies and organizations. An average of nearly nine agencies were selected (ranging from one to 18). Agencies most likely to be indicated are food and nutrition agencies (e.g., WIC) (83 percent) and local health departments or department of public health (82 percent). A majority of programs also reported working with community health centers or local hospitals (75 percent); public schools or local education agencies (LEAs) (66 percent), social service agencies (e.g.,

Temporary Assistance for Needy Families [TANF]) (63 percent), community behavioral or mental health centers (63 percent), and safety net dental clinics (defined as FQHCs, community dental clinics, and county health department clinics) (59 percent). Programs are somewhat less likely to normally work with Part B or Part C IDEA partners (48 percent), colleges or universities (41 percent), job service agencies (41 percent), home-visiting programs (37 percent), family financial-planning organizations (37 percent), and religious organizations (22 percent). Overall, HS/EHS programs are least likely to work with IHS (14 percent), migrant community health centers or tribal organizations (9 percent each), and migrant education organizations (4 percent), although these are more-important partners for Region XI AIAN programs and Region XII MSHS programs (results not shown in the table, given the small number of respondents). For the most part, engagement with each organization type is very similar across HS programs and EHS programs.

Table 13.1. Agencies and Organizations to Work with to Address or Support Health Needs of Children and Families in the Program: By Program Type

Agencies and Organizations	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Agencies or organizations normally work with to address or support the health needs of the children and families in the program			
Average number reported (*N*)	8.9	8.7	9.2
Percentage for each agency or organization (%)			
Social service agency (e.g., TANF)	63.1	65.1	59.6
Food/nutrition agency (e.g., WIC)	82.9	83.3	82.1
Home-visiting programs external to your HS/EHS program	37.4	33.2	44.7
Local health departments, department of public health	82.3	82.1	82.8
Migrant community health centers	9.4	10.3	7.7
IHS	14.0	14.6	12.9
Tribal organizations	8.7	8.7	8.7
Safety net dental clinics (e.g., FQHCs, community dental clinics, county health department clinics)	59.0	58.2	60.3
Community health centers and/or local hospitals	75.3	75.9	74.3
Community behavioral or mental health center	62.8	64.7	59.5
Migrant education	4.3	4.9	3.4
College or university	41.3	40.9	41.9
Religious organizations	21.7	22.5	20.2
Public schools/LEA	65.7	67.7	62.1
Part C and Part B IDEA partners	48.4	45.8	52.9
Programs to provide family financial planning	37.3	36.6	38.5
Job service agency	41.3	40.7	42.5
Legal aid	28.1	26.5	31.0
[Missing]	*11.0*	*9.6*	*13.6*

Table 13.1. Agencies and Organizations to Work with to Address or Support Health Needs of Children and Families in the Program: By Program Type, *Continued*

Agencies and Organizations	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Number of health manager respondents	373	331	205
Number of programs	486	300	186

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

In a follow-up supplemental question, for each agency or organization that a health manager reported working with, he or she was asked to indicate the types of support provided, differentiating among health services (e.g., treatment services), health education, and referrals (i.e., linking families to needed services). For each type of support, health managers could further differentiate between services that are paid for versus those that are provided without payment (i.e., in-kind or donated). The results are reported in Table 13.2 for all but the four agency or organization types with the lowest incidence in Table 13.1.[32] For each agency type (table row), the percentages show the composition of the types of supports received by programs that work with that type of agency. It is evident from the tabulations that when HS/EHS programs work with a given agency, the programs receive an array of health-related services, both paid and unpaid. The provision of health services, either paid or unpaid, is most common for programs working with the first seven agency types, with the highest incidence for safety net dental clinics (32 percent paid and 37 percent unpaid), community behavioral or mental health centers (33 percent paid and 26 percent unpaid), and community health centers or local hospitals (27 percent paid and 32 percent unpaid). For the remaining agency types, from colleges and universities to legal aid, health services are less likely to be provided at all, and when they are, they are more likely to be provided in-kind. In contrast, health education supports are considerably more likely to be unpaid supports when they are provided, with the highest rate for colleges or universities (38 percent unpaid), food or nutrition agencies (36 percent unpaid), and local health departments (35 percent unpaid). Referral supports are also dominated by in-kind provision, with the highest incidence among programs that work with social service agencies (51 percent unpaid), food and nutrition agencies (49 percent unpaid), and Part B and Part C IDEA partners (49 percent unpaid). Across the 14 agency types listed in Table 13.2, at least one-third of programs working with each organization type reported receiving unpaid referral supports.

[32] For Table 13.2, the number of Health Manager Survey respondents fell below 50 for the following four agency or organization types: migrant community health centers, IHS, tribal organizations, and migrant education.

Table 13.2. Health-Related Services Community Partners Provide: All Program Types

Agencies and Organizations	Percentage with Health-Related Services Partners Provide (more than one may apply)					
	Health Services		Health Education		Referrals	
	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid
Social service agency	14.2	20.0	4.3	18.0	13.8	51.1
Food/nutrition agency	16.7	32.5	7.3	35.6	10.6	48.8
Home-visiting programs	20.0	19.3	8.1	24.5	12.7	34.5
Local health departments, department of public health	22.3	38.2	7.4	34.8	10.7	40.8
Safety net dental clinics	32.2	36.5	7.4	31.2	17.8	40.1
Community health centers and/or local hospitals	26.9	32.1	7.7	28.1	16.2	41.0
Community behavioral or mental health center	32.5	25.8	10.9	24.6	21.6	37.9
College or university	7.2	34.0	9.9	38.4	7.5	31.8
Religious organization	3.2	16.3	0.0	19.7	5.7	44.9
Public schools/LEA	9.8	22.3	4.2	20.9	12.3	43.3
Part C and Part B IDEA partners	12.0	23.8	4.9	20.2	12.3	49.3
Programs to provide family financial planning	8.0	10.8	4.2	12.1	9.4	43.5
Job service agency	4.9	8.3	1.5	13.0	11.4	41.8
Legal aid	3.4	10.8	2.5	12.4	10.9	40.1

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 373 health manager respondents for 486 programs. Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentage of missing cases is 20 percent.

Health managers were also asked to indicate, in another supplemental question, the extent to which their community partners are culturally responsive to the ethnic and linguistic minority families served by their HS/EHS programs. Health managers could select from four intervals to quantify the percentage of responsive providers: 0 to 25 percent, 26 to 50 percent, 51 to 75 percent, and 76 to 100 percent. The percentage distribution over these four intervals is reported in Table 13.3, excluding cases where the respondent did not know the answer or the response was missing. In this case, about one in four cases is either missing (about 12 percent, on average) or the respondent could not answer (16 percent, on average). The extent of missing responses may mean that the percentage distributions would look different if we could obtain answers from all respondents, compared with what is observed in Table 13.3 for those who answered. With this caution in mind, we note that the responses appear to indicate that health managers in potentially more than one-half of all HS/EHS programs view most of their community partners (76 to 100 percent) as being culturally responsive. Fewer than 25 percent of programs view only a minority of their partners (0 to 50 percent) as meeting this objective. Moreover, these patterns are almost identical for HS programs and EHS programs.

Table 13.3. Community Partners Cultural and Linguistic Competence: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Percentage of community partners that are culturally responsive to the needs of the ethnic and linguistic minority families in the program (% distribution)			
0 to 25 percent	8.8	9.2	8.0
26 to 50 percent	13.8	14.6	12.3
51 to 75 percent	24.8	23.7	26.8
76 to 100 percent	52.7	52.5	52.9
[Don't know]	*15.9*	*16.0*	*15.6*
[Missing]	*11.8*	*10.5*	*14.0*
Number of health manager respondents	373	331	205
Number of programs	486	300	186

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Gaps in Current Partnerships

To learn more about the shortfalls in current partnerships, health managers were asked to identify the health needs that are not currently being met (or met well) by the agencies and organizations that the programs work with. Table 13.4 shows the responses for all HS/EHS programs combined and by program type for 13 different health-related service areas. On average, health managers selected about three health needs from the list of 13 (ranging from one to 13). Notably, the highest rate of unmet need across HS/EHS programs is for weight-control services (44 percent). But this means that the vast majority of programs feel that their needs are being met in each of the health areas listed in Table 13.4. Other health areas with the highest unmet need include two topics relevant for adult health: smoking cessation (35 percent) and treatment for alcohol or substance abuse (30 percent). Other higher-rated topics are potentially relevant for children as well: environmental health concerns (29 percent), oral health care (29 percent), and behavioral health care (28 percent). The last two topics also arise in the context of the ability of partnerships to meet behavioral and mental health needs (see Table 10.3) and oral health needs (see Table 11.3). All of the other health areas were mentioned by fewer than 17 percent of programs.

Table 13.4. Health Needs Not Being Met by Partner Agencies and Organizations: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Health needs not being met (or met well) by agencies and organizations program works with					
Average number reported (*N*)	2.9	2.9	3.0	3.4	2.2
Percentage for each health need (%)					
Health care	11.5	9.9	14.2	14.6	8.8
Oral health care	29.3	27.7	32.1	21.8	26.0
Behavioral health care	28.0	26.1	31.4	34.8	18.7
Services for children living with disabilities/medically fragile children	14.1	13.9	14.3	23.2	13.0
Asthma management and/or education programs	16.4	15.7	17.5	24.1	17.6
Services for weight control	44.0	42.6	46.6	34.8	44.9
Hearing or vision services	15.0	14.5	15.8	23.5	13.4
Treatment for alcohol or substance use	30.3	31.3	28.4	36.1	16.4
Programs for smoking cessation	34.6	35.6	32.9	38.3	12.7
Services for pregnant women	17.2	19.8	12.6	21.4	6.0
Environmental health concerns	29.1	27.9	31.3	33.5	15.4
Injury prevention or safety concerns, emergency management	14.9	13.8	16.9	24.5	9.1
[Missing]	*19.4*	*19.0*	*20.0*	*20.8*	*17.8*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Again, the incidence of unmet need in each health area was reported to be very similar for HS programs and EHS programs. The rate of unmet need is fairly similar for Region XI AIAN programs, although the rate of unmet need for some health topics (e.g., injury prevention or safety concerns and services for children living with disabilities) is higher by a few percentage points compared with HS/EHS programs overall, but the rate of unmet need is also lower relative to the national average in other cases (e.g., services for weight control). Compared with the rates for all regions, Region XII MSHS programs reported lower rates of unmet need for alcohol or substance use treatment and smoking cessation programs, as well as for services for pregnant women and environmental health concerns. There was a tendency for programs in mostly rural areas to report that a given health need is not being met or met well (e.g., health care, services for children living with disabilities, and asthma management) (see Table H.13.4 in Appendix H). The differences based on program size and health manager health-related education are not substantial.

Health managers were also asked to indicate the organizations that they would like to work with but are not currently working with, with reference to the same list of agencies and organizations included in Table 13.1. The highest incidence for a desired partnership occurs for

legal aid (34 percent), followed closely by a program to provide family financial planning (27 percent), a job service agency (26 percent), and a college or university (24 percent). These are organizations where current working relationships are less likely to exist. For the most part, these patterns are very similar across program type. Region XI AIAN programs were least likely to reference IHS or a tribal organization as a desired partner but somewhat more likely to mention a number of other categories of organizations, including a local health department and a college or university. Region XII MSHS programs were least likely to cite the need for a partnership with a migrant community health center, migrant education center, or a job service agency, compared with other organization types, but these programs were more likely to select a food or nutrition agency, a college or university, and a religious organization as desired partners. When these patterns were examined for subgroups defined by other program characteristics (see Table H.13.5 in Appendix H), there were no large differences.

Table 13.5. Health-Related Community Partners That Programs Would Like to Work With: By Program Type

Agencies and Organizations	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Health-related community partners not working with now but would like to have a relationship with					
Average number reported (*N*)	2.8	2.7	2.8	3.4	2.7
Percentage for each partner (%)					
Social service agency	12.7	11.9	14.1	12.3	11.5
Food/nutrition agency	7.8	8.4	6.8	8.7	18.9
Home-visiting program	13.5	15.1	10.6	12.8	13.5
Local health department, department of public health	5.6	5.4	6.0	20.0	6.7
Migrant community health center	14.2	15.2	12.5	11.8	3.3
IHS	12.6	12.5	13.0	9.5	15.3
Tribal organization	12.3	12.1	12.6	9.0	15.3
Safety net dental clinic	17.3	16.3	18.9	24.3	10.1
Community health center and/or local hospital	12.6	12.5	13.0	19.4	12.8
Community behavioral or mental health center	12.9	12.0	14.5	14.9	17.1
Migrant education	12.1	12.9	10.7	11.6	5.2
College or university	23.6	23.0	24.7	34.2	30.8
Religious organization	15.7	15.2	16.7	15.5	24.6
Public school/LEA	3.3	3.0	3.8	7.8	4.4
Part C or Part B IDEA partner	5.3	5.0	5.9	9.5	6.9
Program to provide family financial planning	26.7	25.8	28.5	32.8	20.2
Job service agency	25.8	24.9	27.4	34.8	12.4
Legal aid	34.3	34.1	34.6	40.4	29.7
[Missing]	*22.5*	*21.7*	*23.8*	*24.0*	*18.0*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Challenges with Meeting Health Needs

To gain more insight into the potential challenges faced by HS/EHS programs in the provision of health services, health managers were asked to rate the extent to which, in the last 12 months, seven potential barriers made it difficult to provide health services or programs to children and families. Table 13.6 lists each factor and shows the percentage distribution across three response categories: made it not at all difficult, made it somewhat difficult, and made it extremely difficult.

Table 13.6. Factors That Impeded the Provision of Health Services or Programs to Children and Families in the Past 12 Months: All Program Types

	Percentage Distribution			
Factors	**Made It Not at All Difficult**	**Made It Somewhat Difficult**	**Made It Extremely Difficult**	***[Missing or Not Applicable]***
Having staff attend IEF or IFSP meetings	60.3	33.3	6.4	*19.1*
Establishing linkages/partnerships with health providers for offering health services (e.g., clinical services)	57.8	38.5	3.8	*15.4*
Establishing linkages/partnerships with health organizations for providing prevention or health-promotion programs	54.9	40.9	4.2	*15.8*
Establishing linkages/partnerships with private resources (e.g., faith based, foundations, business) regarding prevention or health-promotion programs	49.3	41.3	9.4	*17.2*
Sharing health data/information on children/families served jointly by HS/EHS and other agencies	49.3	44.0	6.7	*16.1*
Obtaining timely evaluations of children living with disabilities	39.9	49.5	10.6	*16.9*
Having enough resources to serve health needs of children who do not qualify for Part B and Part C assistance	35.4	53.4	11.2	*19.7*

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Based on 373 health manager respondents for 486 programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed excluding cases that are missing or not applicable and might not sum to 100 because of rounding. The percentages of cases that are missing or not applicable are shown for reference.

Overall, the three factors related to establishing linkages or partnerships with other organizations—with health providers for health services, with health organizations for providing prevention or health-promotion programs, or with private resources regarding prevention or health-promotion programs—were among the least likely factors to be rated as being "extremely difficult" (4 to 9 percent). Although close to a majority or a majority viewed each of these factors as not being a barrier (i.e., "not at all difficult"), a nontrivial percentage—about 40 percent—viewed these as factors that are "somewhat difficult." Sharing health data or information on children and families with other agencies providing joint services with Head Start was also generally viewed as not creating a barrier at all (49 percent), but about 44 percent rated this as a "somewhat difficult" factor, and close to 7 percent rated this as "extremely difficult." Two

factors related to children with special needs were most likely to be rated as somewhat or extremely difficult. In particular, obtaining timely evaluations of children living with disabilities was rated "extremely difficult" by health managers in 11 percent of programs. The ratings were similar regarding having enough resources to serve the health needs of children who are evaluated but do not qualify for Part B and Part C assistance (53 percent "somewhat difficult" and 11 percent "extremely difficult"). A final factor: having staff attend income eligibility form (IEF) or individualized family service plan (IFSP) meetings was also rated by a majority of programs as not being a barrier (60 percent).

Additional Insights on Community Partnerships from Health Manager and Staff Interviews

All HS/EHS staff interviewed confirmed the value and importance of strong community partnerships, both for connections to health services and broader family supports. HS/EHS programs pursue these partnerships in a variety of ways, often building on the work of their HSACs. In general, HS/EHS health managers and other staff felt that they have sound community partnerships for health services. For example, some teachers reported field trips to the local grocery store or farmers' market to learn about healthy foods, while other teachers invited police officers or firefighters to the classroom to speak to the children about safety. While programs value these relationships, they reported that it can be challenging to establish and maintain relationships with community providers. For example, the reported areas of greatest need were consistent relationships with physicians—staff found it difficult to engage physicians given time constraints. A significant amount of time is spent fostering partnerships with local providers serving HS/EHS children to build trust between families and providers. Additionally, some specialty providers, such as mental health providers and pediatric dentists, tend to be in short supply. Thus, those programs that have strong connections with these types of providers are keen to maintain and cultivate the relationships as central to serving their respective HS/EHS populations.

In addition to key partnerships needed for the broader health and related service network, some HS/EHS programs noted that it is important that their health-related staff members are visible and accessible in the community. In particular, this includes HS/EHS programs participating in local health fairs and other community events.

> *In a couple of communities, they do community-wide health screenings, and we take part. We worked with [community college] to do screenings.* —Health manager

> *Some of the hospitals have health fairs, and we link up with them. We try to be there at an event so we can at least do recruitment. . . . We are proactive; when we hear about it, we call to find out if we can be part of it.* —Health manager

In addition to these types of relationships, some HS/EHS programs pursue formal agreements with agencies or providers, consistent with findings reported earlier about the formal partnerships with physical health, behavioral and mental health, and oral health providers (Chapters Nine, Ten, and Eleven, respectively). For some, entering into contractual relationships facilitates reliable and quality partnership and ensures that the referral network for health and other support services is robust. Some staff shared that they review these partnerships routinely to determine whether they are effective and whether they are meeting changing family and community needs.

> *For our migrant centers, we have a partnership with the migrant clinic—community health center. They partner with the physician assistant program at the university here, and, a couple of times of year, they bring a bunch of physician assistant students to do the physicals for them. They also do low blood sugar testing, height and weight, and iron testing for the kids. They are very involved with helping us.* —Health manager

> *We meet every year with health care providers. I don't do it personally, but we stay in close touch with them. If they have a concern about a parent, they will call, and let us know [the family] missed an appointment. I am not part of that. When they meet, we send the health manager and two family partners to meet with providers.* —Teacher

Summary of Chapter Findings

HS/EHS programs engage with numerous community partners to meet the requirements of the health services area and the health-related needs of the children and families the programs serve. Not surprisingly, the vast majority of programs have existing partnerships with food and nutrition and public health agencies. Health managers, however, expressed an interest in building relationships with agencies that fall outside the traditional health sector, including legal aid, financial planning, job placement services, and universities, which suggests that health managers are considering the linkage between health and other social services and see these community partners as providing a value to the health services area. Health managers also reported unmet needs in the areas of weight control, smoking, and substance abuse. While there are few differences between HS programs and EHS in this regard, Region XI programs were more likely to report unmet partnership needs related to injury prevention or safety concerns, as well as services for children living with disabilities. Region XII programs were more likely to report unmet needs around weight-control services and increased partnerships with higher-education institutions and religion-based organizations. With few exceptions, the variation in unmet need is not large based on other program characteristics. One exception is health managers in programs in mostly rural areas, who were more likely to report that some health needs are not being met by existing partnerships.

In addition to these gaps, about one-half of HS/EHS programs did not report significant challenges in developing partnerships, while the other half reported moderate to more-significant

barriers. A clear majority of programs did, however, note that they are concerned about two issues related to children with special needs, in particular: challenges obtaining timely evaluations of children living with disabilities and having enough resources to serve the health needs of children who do not quality for Part B and Part C assistance. There may be ways to strengthen or streamline these partnerships (although they were not explicitly cited by programs as gaps in partnerships) to ensure timely and adequate evaluations, as well as supports, for Head Start's most vulnerable children.

14. Funding for the Health Services Area

In earlier chapters, mention has been made of the resources available to HS/EHS programs for the provision of health services and other aspects of the health services area. Both the Director Survey and the Health Manager Survey touched on aspects related to the funding of the Head Start health services area. Specifically, in this chapter, we discuss the information gleaned about the share of the budget for the health services area and the sources of funds that programs rely on for screening services; physical, behavioral, and oral health services; and health-promotion activities.

Chapter Fourteen Methods

- HS/EHS programs are the unit of analysis
- All results are weighted to be representative of programs.
- Percentage distributions and means are reported for cases with nonmissing values.
- Questions in the online Director Survey and core questions in the Health Manager Survey (various modules) are reported for all HS and EHS programs combined, separately for all HS and EHS programs, and separately for all AIAN programs in Region XI and all MSHS programs in Region XII.
- Core questions are also analyzed by subgroups, defined by health manager health-related education background, program size, and program rural-urban status.
- Supplemental questions are reported for all HS and EHS programs combined and separately for all HS and EHS programs.

The chapter begins with results for the share of the Head Start budget devoted to the health services area and then continues with findings regarding the sources of funds used for screening services, treatment services, and health-promotion activities. These analyses produce the following key findings:

- Among those programs that reported budget data in the Director Survey, the typical program's health services area budget is about 2 percent of the overall Head Start funding, although there is considerable variation around that estimated median.
- In addition to their own budgets, programs draw on a number of other funding sources to pay for various components of the health services area. These sources include public or private health insurance coverage that children and families have, which may cover the cost of screening or treatment services.
- For screening services, public insurance (Medicaid and SCHIP) is the most common source, but private insurance is also common, along with the program's own budget. In-kind contributions from providers also play a role.
- These three sources—public insurance, private insurance, and the program budget—also rank highest in the case of treatment services, and in-kind contributions from providers is yet another source tapped by some programs. About two in three programs reported having a set portion of the overall HS/EHS budget to support medical, behavioral and mental, and oral health treatment services.
- For prevention and health-promotion activities, programs are most likely to reference their own budgets as a source of funds, but provider in-kind contributions and public health insurance are also frequently used.

Any differences in these key findings for Region XI and Region XII programs, as well as relevant patterns by health manager and program characteristics, are reviewed at the end of the chapter.

Budget for Head Start Health Services Area

As part of the Director Survey, directors were asked to state the overall program funding level for the current fiscal year and the amount of the health services area budget for the same year. This information was requested from directors for each HS/EHS grant for which they were responsible. Table 14.1 summarizes the results, reporting the share of the budget for the health services area. In presenting these figures, it is important to note that we do not have an estimate of the health services area budget share for about one-third of all HS/EHS programs. This is because either the director did not reach that part of the survey (partial responses) or because the director did not provide a total budget or a health services area budget. In most of these cases, directors indicated that they did not have a separate budget for the health services area. In addition, for a number of cases where budget information was reported, the estimated budget share is impossibly large (50 percent or more, even exceeding 100 percent), which indicates that there are some errors in the data. Furthermore, about 2 percent of programs have a reported health services area budget of zero. Because of these outliers, we report percentiles of the distribution of estimated budget shares rather than the mean. Results are reported for all HS/EHS programs, separately for HS programs and EHS programs, and for programs in Regions XI and XII.

As seen in Table 14.1, among programs that have a health budget, the typical (or median) HS/EHS program director reported having about 2 percent of his or her annual budget available for the health services area. The health services area budget share is about 2 percent for each of the program types reported in the table. At the 25th percentile (i.e., 25 percent of programs fall below this point), the budget share is less than 1 percent, whereas at the 75th percentile (i.e., 25 percent of programs are above this point) the share doubles to about 4 percent, a pattern that holds across the program types. Directors were asked to indicate what happens if the need for services exceeds the designated budget share. The most common response indicated that directors would reallocate funds in their current budgets to meet the need or seek additional external funds.

Table 14.1. Share of Head Start Budget for Health Services Area: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Share of budget for health services area (percentage)					
25th percentile	0.6	0.5	0.7	0.4	0.3
Median	2.1	2.1	2.3	2.3	1.7
75th percentile	4.2	3.9	4.6	4.8	4.4
[Missing]	*32.0*	*31.1*	*33.6*	*27.2*	*27.5*
Number of director respondents	1,627	1,412	852	107	43
Number of programs	2,330	1,462	868	145	55

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentiles are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Funding Sources for Health Services

As part of the Health Manager Survey, health managers were asked for the sources of funds used to pay for various components of the health services area. With one exception, these were supplemental questions, so we do not report separate results for Region XI AIAN or Region XII MSHS programs in those cases.

Screenings

Table 14.2 shows the sources of funds used to pay for screening services. Just over three sources were mentioned on average (ranging from one to seven, including "other"). As seen in the table, the most common source of funds for screening services is the child or family's insurance coverage through Medicaid or SCHIP (used by 78 percent of programs), followed by the program's own budget (67 percent) and private insurance (61 percent). In-kind contributions from providers are reported to be a source for just under one-half of programs. EHS programs were somewhat less likely to report using in-kind contributions from providers and more likely to use their own program funds.

Physical, Behavioral, and Oral Health Services

In the context of physical, behavioral, or oral health treatment services, health managers were first asked to indicate whether their programs have a set portion of funds designated for such services. As seen in Table 14.3, about 63 percent of programs reported having a set budget designated for treatment services. Interestingly, health managers in about one in five programs reported not knowing whether there is a designated budget for treatment services. The share of Region XI AIAN programs reporting the presence of a designated budget is considerably below the national average (36 percent versus 63 percent), and the reported presence of a treatment budget is even higher than the national average for Region XII MSHS programs (74 percent). Examining differences by other program characteristics in having a designated treatment budget

(see Table H.14.3 in Appendix H) shows that the likelihood of having a set budget increases with program size (from 54 percent for small programs to 72 percent for large ones). An even higher incidence (74 percent) is found for programs in mixed rural-urban areas.

Table 14.2. Source of Funds Used for Screenings: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Sources of funds used to pay for screenings			
Average number reported (*N*)	3.2	3.3	3.0
Percentage for each source (%)			
Medicaid, SCHIP, other publicly funded insurance for children	78.3	78.7	77.6
County indigent funds	9.0	10.2	6.9
Private insurance	61.0	63.5	56.7
Family self-pay, out-of-pocket expense	19.2	20.4	17.0
Grant funding from an external source	12.3	12.7	11.6
In-kind contributions from providers	48.2	51.6	42.2
HS/EHS program budget	67.2	65.0	71.1
Other source	6.7	7.1	5.8
[Missing]	*4.1*	*4.5*	*3.5*
Number of health manager respondents	359	305	186
Number of programs	470	292	178

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Table 14.3 also shows the sources of funds used to pay for physical, behavioral, or oral health treatment services, and the patterns are quite similar to the sources used for screening services: an average of nearly four sources (ranging from one to eight, including "other"). Medicaid or SCHIP is the dominant source (93 percent), followed by private insurance (77 percent), and the program budget (71 percent). These patterns are very similar for HS programs and EHS programs. Notably, Region XI programs reported relying less on all sources, especially their own program budgets (40 percent). Although not a response option, IHS was mention by Region XI programs as another source of funds ("other source"). For Region XII MSHS programs, in-kind contributions from providers are a somewhat more prevalent source of funds (72 percent of programs), as are grant funding (27 percent) and county indigent funds (20 percent).

Examining the use of the various funding sources to support treatment services and examining how funding sources vary by other program characteristics show some important differences. Compared with smaller programs, larger ones are more likely to rely on in-kind contributions (55 percent versus 46 percent) and the HS/EHS program budget (77 percent versus 64 percent). When viewed by rural-urban status, for each source of funds, the highest incidence of use tends to be for programs in mixed rural-urban areas, indicating that they are more likely than programs in more-rural or more-urban areas to rely on multiple funding sources.

Table 14.3. Budget and Source of Funds Used for Treatment Services: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
A set portion of the HS/EHS budget is designated for treatment services for physical, behavioral, or oral health (% distribution)					
Yes	63.4	65.0	60.6	36.3	74.4
No	14.1	14.1	14.1	24.4	16.9
Don't know	22.5	20.9	25.3	39.3	8.7
[Missing]	*6.9*	*6.7*	*7.3*	*12.4*	*11.9*
Sources of funds used to pay for physical, behavioral, or oral health treatment services					
Average number reported (*N*)	3.6	3.6	3.6	3.2	3.8
Percentage for each source (%)					
Medicaid, SCHIP, other publicly funded insurance for children	93.2	93.6	92.6	90.5	100.0
County indigent funds	8.5	8.7	8.0	6.2	20.1
Private insurance	77.4	77.5	77.3	77.1	60.9
Family self-pay, out-of-pocket expense	35.0	34.9	35.1	24.2	17.9
Grant funding from an external source	16.4	15.4	18.0	10.4	27.2
In-kind contributions from providers	51.1	52.5	48.5	41.3	72.1
HS/EHS program budget	70.6	71.1	69.7	40.0	76.7
Other source	6.4	6.4	6.4	25.7	0.8
[Missing]	*1.3*	*1.1*	*1.6*	*1.8*	*0.0*
Number of health manager respondents	1,465	1,264	795	76	46
Number of programs	1,902	1,176	726	101	48

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Health-Promotion Activities

Health managers were asked about the sources of funds used to pay for prevention and health-promotion activities (see Table 14.4), family health-promotion activities (see Table 14.5), and staff-wellness activities (see Table 14.6). For the first two types of activities, just under three sources were reported on average (ranging from one to six and one to eight supports, respectively), while the average was under two sources for the staff-wellness supports (ranging from one to five supports). For these three types of health-promotion activities, the most common source of funds is the program's own budget—about 70 percent of programs for general health promotion and family health promotion and 50 percent of programs for staff wellness. Provider in-kind contributions and Medicaid/SCHIP are also important sources. These patterns are very similar for HS programs and EHS programs.

Table 14.4. Source of Funds Used for Prevention and Health-Promotion Activities: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Sources of funds used to pay for prevention and health-promotion activities			
Average number reported (*N*)	2.6	2.6	2.6
Percentage for each source (%)			
Medicaid, SCHIP, other publicly funded insurance for children	41.4	39.5	44.8
County indigent funds	2.4	2.8	1.7
Private insurance	24.1	23.8	24.5
Family self-pay, out-of-pocket expense	9.3	8.6	10.7
Grant funding from an external source	23.3	24.0	22.1
In-kind contributions from providers	57.5	57.7	57.0
HS/EHS program budget	69.0	69.0	69.1
Other source	8.2	8.3	7.9
[Missing]	*10.6*	*11.3*	*9.6*
Number of health manager respondents	357	305	200
Number of programs	465	286	179

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for nonmissing cases. The percentages of missing cases are shown for reference.

Table 14.5. Source of Funds Used for Family Health-Promotion Activities: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Sources of funds used to pay for screenings			
Average number reported (*N*)	2.5	2.4	2.5
Percentage for each source (%)			
Medicaid, SCHIP, other publicly funded insurance for children	32.7	32.0	33.9
County indigent funds	2.0	2.3	1.6
Private insurance	17.4	17.6	17.1
Family self-pay, out-of-pocket expense	8.5	8.8	8.1
Grant funding from an external source	27.5	28.2	26.3
In-kind contributions from providers	58.7	59.1	57.9
HS/EHS program budget	70.7	68.9	74.0
Other source	5.3	4.7	6.3
[Not applicable]	*3.6*	*3.1*	*4.5*
[Missing]	*10.3*	*10.0*	*10.7*
Number of health manager respondents	357	305	200
Number of programs	465	286	179

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentages are computed for applicable and nonmissing cases. The percentages of not applicable and missing cases are shown for reference.

Table 14.6. Source of Funds Used for Staff-Wellness Activities: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only
Sources of funds used to pay for screenings			
Average number reported (*N*)	1.6	1.6	1.6
Percentage for each source (%)			
Medicaid, SCHIP, other publicly funded insurance for children	4.0	4.3	3.5
County indigent funds	0.0	0.0	0.0
Private insurance	17.9	17.7	18.1
Self-pay, out-of-pocket expense	15.7	15.9	15.3
Grant funding from an external source	14.2	13.1	16.0
In-kind contributions from providers	33.7	36.6	28.7
HS/EHS program budget	51.7	52.3	50.9
Other source	9.6	7.7	12.8
[Not applicable]	*15.5*	*16.9*	*13.1*
[Missing]	*11.4*	*10.5*	*13.0*
Number of health manager respondents	376	323	204
Number of programs	483	298	185

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTE Results are weighted to account for survey nonresponse. Percentages are computed for applicable and nonmissing cases. The percentages of not applicable and missing cases are shown for reference.

Summary of Chapter Findings

Several questions from the Director Survey and the Health Manager Survey provide insights into the financial sources that programs rely on to support the health services area. The majority of programs reported a designated budget for the health services area, but it is typically a small share (about 2 percent) of the overall program budget. According to Health Manager Survey responses, these program funds are used to cover the full range of services, from screening, to treatment, to prevention and health promotion. But other sources of funds also come into play, particularly public health insurance and private health insurance to cover screening and treatment costs, and to a lesser extent prevention and health-promotion services. For the most part, these patterns are very similar for both HS programs and EHS programs.

For the overall health budget, Region XI AIAN programs and Region XII MSHS programs reported, at the median, similar shares as the national pattern. Most of the other funding questions were included in the supplement, so we cannot tally responses separately for these two regions. However, all health managers were asked about funding for treatment services, and Region XI and Region XII health managers have somewhat different patterns from programs nationwide. In particular, Region XI AIAN programs were less likely to report any of the possible funding sources in the response set and more likely to write in IHS as a source of funds. Compared with the national average, Region XII MSHS programs are more likely to rely on in-kind contributions from providers and more likely to mention a few other less common sources, such as grants and county indigent funds. We also identified some differences in the use of funds for treatment services by different program subgroups. Notably, there was a clear increase with

program size in the percentage of programs that reported using a set portion of their budgets for treatment services.

15. Crosscutting Issues

Chapter Fifteen Methods

- Insights from the interviews with health managers and other staff and open-ended survey responses are integrated with findings from earlier chapters from the Health Manager Survey.

Health managers and staff noted a number of challenges that they face in the execution of various health-related tasks. Although many of these challenges have been noted throughout the report, five were raised most often by health managers throughout the survey and interviews and in their responses to one open-ended question on the survey, which asked, "Is there anything that you would like to share, either positive or negative, about your experience with the health services area of your program and/or the health needs of children and families in your program?" These challenges are considered crosscutting, and deserve further attention:

- There are too many requirements and not enough time. Health managers felt that the amount of time required to track every child against every requirement precludes them from doing other health-related activities that they consider to be more important for health.
- There is a lack of clarity around some Head Start standards. In some cases, Head Start standards in the health services area are not overly prescriptive. While this is helpful in some regards, the ambiguous nature of the standards results in some health managers feeling as if they do not fully understand what is expected of them or the health services area.
- Providers do not always offer the health screens and services required for Head Start. Many health managers reported significant amounts of time required to educate providers on the necessity of Head Start requirements. Health managers mentioned numerous instances where providers are not conducting necessary screenings. However, challenging providers on these points undermines their credibility and puts the family in an uncomfortable position of being in the middle of two trusted entities.
- Programs are being held accountable for parent or provider behavior. A related issue is that health managers felt that it is unfair to hold them accountable for the actions (or lack thereof) of parents and providers with whom they have been working when health behaviors have not changed. Health managers noted that there perhaps should be additional strategies for ensuring that families are more accountable for meeting program requirements. Issues with the availability of providers and ones who will accept health insurance coverage also need to be taken into account.
- Some health managers perceive that the health services area receives lower priority. Several health managers reported that overall there seems to be a lack of emphasis on the health services area on the part of OHS and program leadership relative to other areas of programming (e.g., school readiness) and that what emphasis there is has declined over time. Health managers are concerned that this is contributing to cuts in health personnel and budgets.

There Are Too Many Requirements and Not Enough Time

In Chapter Three, the top rated job challenge mentioned by 62 percent of health managers was time constraints, a theme the appeared in subsequent chapters as well. As noted in Chapter Four, on staffing, for example, a majority of health managers expressed a frustration about the time required to track every child, on multiple data points, to demonstrate that they are meeting their performance standards. Results presented in Chapter Twelve reveal that health managers are frustrated about the sheer number of requirements and felt that some of these activities are pulling them away from what they consider to be more important, which is focusing on prevention and health promotion. These frustrations also came to light Chapter Twelve, when we asked health managers about how they are monitoring and evaluating the effectiveness of their health-promotion activities. Health managers very often reported that they do not believe such monitoring and evaluation is possible when so much of their time is devoted to "paper chasing." These sentiments were even stronger for EHS programs, where frequent well-child visits and immunizations require tracking down relevant information every three to six months.

> *I wish we didn't have to have so many regulations. I wish we could let some things go back to being the responsibility of the parents. These regulations and forms are the offensive part. We are all believers, but the regulations are a bit far out there.* —Health manager

> *I have been here seven years. Compliance with paperwork, and creating reports and data tracking, and ensuring new staff are trained take 97 percent of my time.* —Health manager

> *Head Start needs to look at the current reality for many of our families. The standards that we have may have worked back when many of our families did not work; however, the majority of our families work and the expectations we place on them can, at times, become a financial burden. When Head Start forces parents to choose between working or taking a day off (often without pay in our migrant communities) to go to the dentist, we will always lose.* —Health manager

There Is a Lack of Clarity Around Some Head Start Standards

As noted in Chapter One, the Head Start Program Performance Standards are specific in some requirements, but often they are not overly prescriptive with respect to how required services and activities are to be implemented. For example, the standards require "screening for developmental, sensory, and behavioral concerns" (CFR 1304.20(f)(1)). However, the standards do not indicate the specific developmental or behavioral health areas that programs must provide screening for, nor do they dictate whether those screening services are to be provided on-site or off-site or specify who should conduct the screenings. Likewise, other aspects of the performance standards are not specific about the exact services to be provided, who should provide them, the context in which they are to be provided, the mechanisms for ensuring parent involvement, and the approaches to engaging community partners. In some cases, state licensing requirements provide some additional specificity, and OHS has also provided policy guidance in

the past. Nevertheless, Head Start health managers have significant flexibility to focus on health issues that are priorities for their populations and to implement policies in a way that maximizes center and community resources within the framework and constraints of internal organization and operating structures. While this is helpful, a number of health managers felt that there needs to be more clarity about what is expected of programs.

> *I have been surprised and disappointed by the ambiguous (if not poor or absent) direction provided by HS/EHS performance standards and national HS/EHS office and training centers. I understand the need for interpretive standards of practice that permit local autonomy, BUT . . . Early Head Start is suffering greatly from inconsistent direction, and from screening and assessment tools, curricula, and program practices that differ substantively from one program to another.* —Health manager

> *Health managers should be allowed to ask questions regarding performance standards without feeling as though they will be considered insufficient and their programs will be scrutinized. I think the federal HS/EHS program staff need to remember that often times, parents are hired as staff and need much education to become knowledgeable and efficient in their positions. For this reason, I would encourage those who write standards and policies to do so using wording that is well explained and easily understood.* —Health manager

> *I suggest that HS/EHS provide health managers with very specific training about program requirements, expectations, and implementation. At national trainings, there is a trend for the presenters to clarify that they cannot provide specific guidance or answers about HS/EHS regulations. [It] is very difficult for health managers to be specific and effective at their site.* —Health manager

Providers Do Not Always Offer Health Screens and Services Required for Head Start

In addition to the substantial amounts of time it takes to complete paperwork around regulations, health managers in several regions noted that the regulations are creating challenges and tensions with providers. To be in compliance with standards, health managers have to have documentation that each child in the program received the required EPSDT screenings. However, not all providers believe that the screenings are necessary, and as a result they do not conduct them. This places a tremendous burden on the health manager—this is no longer an issue of tracking down paperwork but convincing the clinician that the standards of practice are incomplete or flawed. Several health managers noted that the providers should be following EPSDT guidelines, assuming that providers are obtaining Medicaid reimbursement, but note that many simply are not. Lead screening was most often discussed as a test that does not happen, particularly for children considered low risk. But beyond the increase in the workload for the health manager to convince each clinician to conduct the required tests, this tension causes bigger challenges—health managers noted concern that they may be perceived as undermining the trust the clinician has built with the family.

> *Some physicians have their own immunization schedules in order to break them up. So this is out of alignment with Head Start schedules. They give some immunizations in the early part of the window and others in the later part. I can't send a letter to parents saying they are behind when the parents are engaged and going to their providers who just break it up differently.* —Health manager

> *It's sending the message that Head Start is in control and not the physician, decreasing the credibility of the provider who has worked with the family since birth. I don't want to do that to the medical community—how dare we tell them how to manage their patients.* —Health manager

> *A lot of times, parents are totally on board but the doctor is not on board. We see this with lead screening. When mom asked for lead screening, the doctor said they didn't need it. This is a problem because the parent is getting two separate pieces of information from two trusted sources.* —Health manager

Programs Are Being Held Accountable for Parent or Provider Behavior

The challenge noted above with respect to differences between Head Start expectations, particularly the EPSDT requirements, and provider standards contributes to another concern on the part of health managers: HS/EHS programs are essentially being held accountable for parent and provider behavior, with few—if any—options for recourse. Health managers noted, for example, that they are held responsible for ensuring that all children receive required screenings and health-related services and are considered out of compliance if families do not follow through. As noted throughout the report (see especially Chapters Nine, Ten, and Eleven), getting parents to understand the value of health-related services is one of the most frequently reported barriers within the health services area. It is not surprising, therefore, that health managers reported spending a significant amount of time trying to get parents to do what is required. Health managers noted that they cannot compel families to comply, as Head Start services are not withheld from eligible children even though they have not fulfilled all health requirements

The role that provider shortages and insurance coverage play also received mention, because even parents who are willing and able to seek treatment and other health services may discover that they cannot find a provider they can get to or a provider who will accept their insurance coverage. In some cases, both parent behavior and provider constraints are at play.

> *It is often difficult to meet all the requirements of the Head Start program when there is lack of [dental] providers in the community and lack of interest by the parents to follow through.*

> *It is very frustrating that the oral health needs are barely being met because there are not enough dentists to serve them or their hours of practice are not convenient for families. In addition, insurance requirements make it difficult for dentists to get reimbursed for services when another dentist has already performed the initial exam.* —Health manager

Similar frustrations were raised with regard to providers' treatment services, because health managers cannot force providers to perform certain services if they are simply unwilling. Yet

this may again result in a program becoming out of compliance. Several health managers voiced frustration at being held accountable for other people's actions, particularly when an intense amount of effort has been expended with the family or with the provider in an attempt to get the child the services he or she needs.

> *Our nurses started doing lead sticks since we couldn't get providers to do it. Providers aren't doing what they are supposed to, but Head Start is being held accountable.* —Health manager

> *HS/EHS staff spend a great deal of time and effort in getting parents to fulfill their role. It would be very helpful if programs could create policies/procedures that carried consequences for all areas of health requirements, not just certain ones. For example, the percentage of children with up-to-date immunizations is 100 percent because there is a policy that states that a child is not able to attend class when an immunization is 30 days past due. However, programs are not allowed to exclude children who have not met other health requirements. This sends a mixed message to families that immunizations are important and other requirements are not.* —Health manager

> *I feel that there is undue pressure placed on health managers and staff. The Office of Head Start expects us to educate and inform local medical and dental providers of what is best practice. This is very inappropriate, damages professional relationships, and causes a negative perception of the HS/EHS program. We are also held accountable for whether or not parents complete all program requirements. Being held accountable for whether or not parents complete program requirements affects relationships and causes a great deal of stress.* —Health manager

Several respondents noted that if HS/EHS programs are to remain accountable for provider actions, then OHS should take more of a leadership role to educate and train providers on Head Start standards and work directly with providers who are less responsive. That would take this particular burden off the local programs.

> *Head Start needs to take a role in providing advocacy to the medical community to hold doctors/clinics accountable for providing EPSDT requirements, if we are then required by OHS to uphold these mandates. We are having to provide more and more clinics at the school to ensure that children are up-to-date and in compliance for EPSDT requirements. Is this really the role of Head Start?* —Health manager

> *I am hoping that the OHS and HHS [Department of Health and Human Services] have a conversation regarding the health requirements for Head Start, and the health provider's accountability in fulfilling the health screenings addressing all areas needed, and for following the EPSDT requirements for hearing, vision, lead, and hemoglobin.* —Health manager

Some Health Managers Perceive That the Health Services Area Receives Lower Priority

Among the job challenges identified by health managers discussed in Chapter Three, there was a small minority (13 percent) who felt that they do not have enough support from program leadership or that the organizational culture does not prioritize health. This issue surfaced more prominently in the health manager interviews. Several health managers reported that overall there seems to be a lack of emphasis on the health area within HS/EHS programs. More concerning, many had noticed a decrease in the relative emphasis of the health services area over time. The basis for these perceptions stems from observations that many programs have reduced the number of health staff and have cut or held budgets steady, which results in increases in the health manager workload to ensure compliance with Head Start performance standards and to manage the day-to-day operations of the health services area. As noted in Chapter Four, some health managers noted lower compensation and higher workload relative to other staff within HS/EHS programs, which contributes to the perception that health services is of lower value to programs.

> *Due to budget constraints, the quality of services we are able to provide appears to be strained. The workload of management staff impacts the ability to monitor and ensure quality. This in turn filters down to staff, making them feel less supported.* —Health manager

> *When I started here, the health team was five [people] strong. Now we are down to two of us. Lots to do, so little time.* —Health manager

> *The health staff has been cut in the last 3–4 months, and getting all the work done is very challenging.* —Health manager

Some health managers expanded on this point and suggested that this shift is being driven, in part, by OHS. Although OHS has created the Head Start National Center on Health and does view health as central to its programming (and has since inception), the current emphasis on school readiness may be inadvertently contributing to a misunderstanding among HS/EHS directors and other program leadership that the limited funds that programs have should be focused on these more-academic outcomes. Because we did not explore this issue specifically within the Director Survey, it is not clear whether resource allocations away from health are being driven by explicit or implicit messages directors are hearing from OHS or the regional offices, or whether such decisions are being driven by other factors.

> *I believe in this program with my whole heart and have many success stories with my children. However IHS and Head Start in my opinion have slowly faded out health. Everything is about education. We seem to have lost sight that if the child is not healthy, he or she cannot learn. I am very disappointed with the direction Head Start is going. Even the trainings all deal with education; very rarely are they health related. AIAN does not seem to support health, so why would our directors put effort into it?? Is there even a health person to whom you can go if you have a question?? If so, I do not know.* —Health manager

> *Currently, OHS has put so much focus on school readiness that I feel some of the health education has taken a backseat.* —Health manager
>
> *There is a lot of emphasis on academics with Head Start, and some things like health seem to have taken a backseat to that emphasis.* —Health manager

Summary of Chapter Findings

This chapter highlighted five crosscutting issues that touch on a number of topics covered earlier in the report from the surveys and interviews, as well as additional findings discussed in the chapter. These include having too many requirements and not enough time, a lack of clarity around some Head Start standards, issues in alignment between Head Start standards and provider practice, program accountability for parent and provider behavior, and a lack of focus or emphasis on the health area Although these are challenges that require additional thought and resources, resolving these issues is likely to have a positive impact across multiple aspects of the health services area.

16. Conclusions and Implications

The Head Start Health Manager Descriptive Study is the first study in more than two decades to conduct an in-depth examination of the health services area within Head Start. It is also notable in seeking information from all HS/EHS programs, including those in Region XI (AIAN programs) and Region XII (MSHS programs). As a result, this study provides a much-needed look at health staff, training, programming, services, and community linkages across program types to support the health of children and families within Head Start.

In the first part of this concluding chapter, we highlight the central findings that follow from our quantitative and qualitative analyses, using the study organizational framework (Figure 1.1) to organize the results. We then discuss the implications of our results for the health services area in terms of the health services area workforce; professional development, training, and technical assistance; the health management of individual children; health promotion; community linkages; health services area requirements; Head Start messaging regarding the health services area; and the role of information.

Findings from the Head Start Health Manager Descriptive Study

Chapters Three to Fifteen provide detailed information on the health manager workforce; staffing and professional development to support the health services area; the HSAC; health issues for Head Start children and families; health management of individual children; health services provided by HS programs and EHS programs; coordination with community resources to support all areas of health; health-promotion activities; community partnerships; prioritization, selection, and implementation of health programming; crosscutting issues; and funding for the health services area. In Table 16.1, we distill our results into a smaller set of key findings that emerged from our detailed analyses. The findings are grouped into four themes consistent with our organizational framework (Figure 1.1):

- staffing and managing the Head Start health services area, based on results presented in Chapters Three to Five
- the landscape of HS/EHS programs and services for physical health, behavioral and mental health, and oral health, drawing on results described in Chapters Six to Twelve;
- prioritizing, implementing, and sustaining Head Start health services and activities, derived from results in Chapters Four to Fourteen
- community partnerships and other resources supporting the Head Start health services area, based on results in Chapters Eight to Thirteen.

Table 16.1. Summary of Key Findings

Staffing and Managing the Head Start Health Services Area
• The health manager workforce is diverse in terms of personal characteristics and brings relevant health-related education, training, and professional experience to the job • The health manager position is a demanding job with many challenges, but health managers are dedicated to and find satisfaction in their work • Many HS/EHS staff and consultants contribute directly or indirectly to the health services area • HS/EHS programs recognize the need for ongoing training and professional development in the health services area for all staff, although some training could be made more applied • The HSAC serves an important function in linking programs to a diverse array of stakeholders and providing supportive resources for HS/EHS programs
Landscape of Head Start Physical, Behavioral and Mental, and Oral Health Programs and Services
• Geocoded data demonstrate that HS/EHS programs are in diverse communities with, on average, more minorities, high child poverty, and shortages in health care resource, compared with the U.S. average • Health managers identified an array of health concerns affecting children and families, although overweight and obesity and tooth decay are consistently at the top of the list • Almost all HS/EHS programs track child health information using a formal (electronic) system, but the variety of sources involved and the frequency with which records must be updated are viewed as burdensome • Almost all programs reported conducting the required health screenings (e.g., developmental, sensory), and other screenings as well, using a variety of strategies to ensure that screenings are performed and that parents follow up where indicated • A range of health services is offered on-site, such as speech therapy, behavioral or mental health services, care or therapy for children living with disabilities, and oral disease prevention (e.g., fluoride), and most programs offer multiple services • Most programs provide a number of other health-related services (e.g., assistance enrolling in insurance coverage, parent education and workshops), which extend the comprehensive nature of what is offered • For all types of health services (screenings, physical health, behavioral and mental health, and oral health), health managers identified several common barriers to ensuring that children receive needed services • HS/EHS programs address a wide array of health-promotion topics in classrooms, with parents, and in the home, but programs do not always use evidence-based curricula • Staff-wellness activities are less common than the health-promotion activities offered for families
Prioritizing, Implementing, and Sustaining Head Start Health Services
• Health managers draw on a wide range of resources to inform their choices of health services and activities in the areas where they have the most discretion (e.g., staff training, health promotion) • Health managers use varied approaches for prioritizing and implementing health activities, with processes tailored to the specific circumstances of activities implemented with staff, in the classroom, with parents, or in the home • Programs use multiple strategies to engage families in the full range of health services and supports; obtaining buy-in from teachers and other staff is also important • Funding for health services comes primarily from program funds, public or private health insurance coverage, and in-kind contributions from providers • Monitoring efforts focus on process rather than outcomes, with health managers lacking time or expertise to undertake more-rigorous evaluation

Table 16.1. Summary of Key Findings, *Continued*

Community Partnerships and Other Resources Supporting the Head Start Health Services Area
• To coordinate physical health services, most programs rely on formal mechanisms with providers (e.g., MOUs), and most programs view their partnerships as adequate or very adequate • Formal mechanisms also predominate in relationships with behavioral and mental health providers, but these mechanisms are somewhat less likely to be viewed as adequate or very adequate • Compared with physical health services, partnerships with oral health providers are somewhat less likely to be formalized or viewed as adequate or very adequate • Programs work with a wide range of other community partners, and, while these relationships are viewed as valuable, they require a significant investment of time to develop and maintain, and some gaps exist
Crosscutting Issues Identified by Health Managers
• There are too many requirements and not enough time • There is a lack of clarity around some Head Start performance standards • Providers do not always offer health screens and services required for Head Start • Programs are being held accountable for parent or provider behavior • Some health managers perceive that their Head Start program leadership or OHS places a lower priority on the health services area

The several crosscutting issues identified in Chapter Fifteen are listed as well. These high-level findings are meant to convey the broader-based conclusions that flow from our analyses and should not detract from the fact that the health services area is far from uniform in its structure and delivery across the country's nearly 3,000 HS/EHS grantee and delegate agencies.

Health Services Area in Head Start versus Early Head Start

The conclusions, enumerated in Table 16.1, apply equally well to the health services area in Head Start and Early Head Start. As would be expected given the differences in the focus on pregnant women, infants, and toddlers in the Early Head Start and preschool-age children in Head Start, there are naturally differences in the underlying health concerns and in the corresponding priorities for health screening, treatment, prevention, and promotion. In many cases, however, health managers are overseeing the health services area for grantees or delegate agencies that operate both HS programs and EHS programs. Thus, there is inherently a high degree of overlap in how the health services area is managed and the services delivered in HS programs and EHS programs.

Findings for Region XI AIAN and Regions XII MSHS Programs

One aim for this study was to be inclusive of all HS/EHS programs. Additional resources were devoted specifically to seeking approval to include Region XI AIAN directors and health managers in the online survey frame and in the semistructured interviews, and Region XII MSHS programs were included as well. For survey questions included in the core, we reported

results for these two regions separately to investigate possible differences in the health services area. In many respects, our results show that Region XI and Region XII programs, on average, mirror many of the same features as the average HS/EHS program nationwide. Thus, the central findings of the study highlighted in Table 16.1 apply equally well to Region XI and Region XII programs. We did, however, find a number of differences for Region XI and Region XII programs. It is important to keep in mind that any differences we observe for AIAN and MSHS programs may reflect underlying variation in the populations of children and families served, in the internal and external resources available to the HS/EHS programs, and in the background and competencies of the health managers and other health services area staff. As a descriptive study, we are interested in documenting the patterns but are not able to explain the reasons for any differences we observe.

Region XI AIAN Programs

With those caveats in mind, a number of differences for Region XI AIAN programs merit mention. According to county-level indicator and geocoded data, Region XI AIAN programs are more likely to be in counties in areas with shortages in mental health professionals. The centers operated by AIAN programs are also less likely to have nearby health-related resources, such as mental health providers who accept Medicaid, a Federally Qualified Health Center (FQHC), a hospital, or a health-related professional school. The health manager workforce in Region XI programs draws from members of the AIAN community, and they are more likely to have experience in prior HS/EHS positions, compared with health managers across all regions. However, they are less likely to have a health-related education background. Compared with the average across all regions, health managers in AIAN programs have oversight over a smaller number of sites, but they are more likely to serve in multiple roles.

Although Region XI health managers reported some differences in the most-important health issues that they face (e.g., ear infections, diabetes, and child abuse and neglect), for the most part, the provision of on-site health services is very similar to that of the average HS/EHS program. At the same time, AIAN programs are less likely to have a set budget to pay for health-treatment services. Instead, to support such services, AIAN programs rely less on their own budget and more on other sources, such as the IHS. Health managers in AIAN programs were somewhat less likely to view their current partnerships with physical health providers as adequate for meeting the needs of children living with disabilities. These health managers were also less likely to rate their relationships with behavioral and mental health providers as adequate, but there is no difference with the rating of the adequacy of their relationship with oral health providers. In addition, AIAN programs were somewhat more likely to report unmet partnership needs related to injury prevention or safety concerns and services for children living with disabilities Where we could examine differences in reported barriers to the implementation of various health services, Region XI AIAN programs tended to identify a similar set of issues as all HS/EHS programs on average.

Region XII MSHS Programs

In the case of Region XII MSHS programs, there are also several salient differences. The county-level indicators and geocoded measures of health resources also show that MSHS programs are more likely to be in counties with health professional shortages and to have centers located at greater distances from health-related providers and facilities. About one-quarter of health managers in MSHS programs are Latina or Latino, higher than the share for the overall HS/EHS health manager workforce. These health managers are also more likely to have a health-related education background compared with the overall average. Health managers in MSHS programs typically have oversight over a larger number of sites, compared with the average health manager nationwide, but they are more likely to exclusively serve in the health manager role.

The prevalence of major health concerns facing children in Region XII MSHS programs also differs from the national pattern, with more mentions by health managers of overweight and obesity and tooth decay or cavities, for example. Compared with HS/EHS programs overall, Region XII programs have a higher share offering several types of on-site services: physical exams, immunizations, and oral disease prevention. Several other services are less likely to be offered on-site—specifically, behavioral or mental health care, physical therapy, and speech therapy. To pay for treatment services, MSHS programs were more likely to report using several sources of funding that are less commonly used by programs overall—grant funding and county indigent funds. Health managers in MSHS programs were less likely than health managers nationally to rate their current partnerships as adequate for meeting the physical health needs of children living with disabilities. Their ratings of the adequacy of relationships with behavioral and mental health and oral health providers are comparable to the rates for all HS/EHS programs. At the same time, health managers in MSHS programs were more likely to report a need for community partnerships around food and nutrition services, higher education institutions, and religion-based organizations. For the most part, health managers in Region XII MSHS programs identified a similar set of barriers to working with families in the health services area as other programs nationally.

Variation in Survey Responses by Heath Manager and Program Characteristics

Our descriptive analyses also explored differences in responses to core survey questions using three other stratifying variables: health manager health-related education background, program size, and program rural-urban status. These descriptive analyses identified some differences but also reinforced the similarity in the health services area across programs with varying characteristics.

As noted in Table 16.1, health managers bring varied education, training, and experience to their role. Given that this is an area of program discretion, there is interest in understanding whether there are differences in how the health services area is organized and functions based on the health manager's background. We explored this issue by looking at differences by the health manager's health-related education background. Those differences that we did identify may

reflect the hiring and staffing patterns used by programs or the differential choices that health managers make in administering the health services area based on their health-related backgrounds.

Our descriptive analyses shows that the health-related education background of the health manager has some relationship to the health manager role and how he or she plans for health activities. Those with bachelor's degrees or higher in a health field, or one or more health-related credentials, are more likely to serve exclusively in the health manager role and to have more-frequent contact with other health managers. For program planning, programs where the health manager has a health-related bachelor's degree draw on a different mix of resources, such as the health manager's own experience with a curriculum or other external resources. At the same time, the health manager's background is not strongly associated with the general types of services offered (e.g., medical services, services in the home, services for pregnant women). For some specific services, the services are offered at a higher rate in programs where the health manager has a health-related degree, but the differences are quite modest (e.g., differentials of at most 10 percentage points). Where difference exist, this may indicate that programs that offer various health-related services are more likely to hire a health manager with health-related education or that health managers with a health background are better able to offer these services. There are no discernible differences based on health manager background in how adequate health managers rated their partnerships with physical, behavioral and mental, or oral health providers.

Program size (defined using funded enrollment as recorded in the PIR) potentially affects the resources and capacity available to the health manager. At the same time, management challenges may rise as the scale of the program increases. As a readily identifiable indicator, program size could be used to target programs that appear to need more supports. However, it is important to keep in mind that any differences in survey results we identify based on program size may reflect the role that size plays, per se, or the role of other factors that are correlated with program size.

Interestingly, compared with the measure of the health manager's background, we found fewer important differences in survey responses based on program size. Some differences pertain to the structure of the health manager position and other administrative functions. In particular, health managers in smaller programs, compared with larger ones, are more likely to serve in other roles in addition to the health manager and to have less frequent contact with other health managers. The size and composition of the HSAC varied with program size, with larger programs having larger HSACs with more-varied representation among some types of stakeholders. In some areas, larger programs, compared with smaller ones, tended to have more-formal supports for the health services area, such as an electronic tracking system. In selecting topics for health-promotion activities, health managers in larger programs appear to rely on a larger set of resources. For the most part, however, the rates at which health services are offered on-site do not vary in a substantial way with program size. There are two exceptions out of the

11 services covered in the survey. First, there is a higher rate of offering physical exams and oral health treatment in large programs, compared with medium or small programs, but the differences are no larger than 10 percentage points. Second, as program size increases, EHS programs are somewhat more likely to offer services to pregnant women, but the specific services offered among those with services generally did not vary with EHS program size. The rates at which different approaches are taken to ensure parent follow-up are quite similar across the program-size categories. Finally, there are no meaningful differences in how adequate health managers rated their partnerships with health providers based on program size.

Finally, the context within which HS/EHS programs operate, such as the availability of health care providers and other community partners, potentially affects how health managers and other staff deliver Head Start health services and activities. Although we gathered a number of geocoded measures to examine these issues, most were at the county level, which does not capture more-localized features of the context within which HS/EHS programs operate. For this reason, we used a measure of the proportion of a program's centers that are located in a rural versus urban census track, classifying programs as located in mostly rural areas, mixed rural-urban areas, and mostly urban areas. Again, differences in survey results associated with urbanicity may result from differences in resource availability or the role of other factors that are correlated with rural-urban status.

In many respects, rural areas mimic the findings for small programs and urban areas the findings for large programs. Health managers in programs in mostly rural areas, compared with those in mostly urban ones, are more likely to have other roles and to have less frequent contact with other health managers. As urbanicity increases, programs are more likely to have multiple HSACs and to share their HSACs. The size of the HSAC is also larger with greater urbanicity and with somewhat more-varied representation. Programs in mostly urban areas, like larger programs, tend to have more-formalized structures and supports, such as an electronic tracking system, and rely on a wider set of resources (for example, when planning for health-promotion activities). There is some variation in the propensity to offer specific health services by urbanicity, with the rate being higher in some instances for programs in mostly urban areas and the reverse pattern—a higher rate for programs in mostly rural areas—for other services. For the most part, the use of strategies to ensure parent follow-up is the same regardless of rural-urban status. The incidence of offering home-based services is lower in programs in mostly rural areas compared with programs in mixed or mostly urban areas. Although the likelihood of EHS programs offering services to pregnant women does not vary with urbanicity, among EHS programs offering services to pregnant women, there are some referral services that are less likely to be offered by EHS programs in mostly rural areas. There are no discernible differences, however, in how adequate health managers rated their partnerships with physical, behavioral and mental, and oral health providers based on program urbanicity.

Implications of Study Findings

The findings highlighted in Table 16.1 span the breadth and depth of the health services area. In this section, we draw out a number of implications for specific aspects of the Head Start health services area. We focus in particular on those pertaining to the health services area workforce, professional development, health management of children, health promotion, and community linkages. We also discuss three higher-order implications related to health services area requirements, messaging regarding the health services area, and informational needs.

Implications for the Health Services Area Workforce

The survey data show that health managers bring varied backgrounds to their role in terms of education, training, and experience. For example, some health managers have a health background, while others come from an early childhood background and work with nurses who bring health-related expertise. This varied approach to staffing the health services area is consistent with the Head Start performance standards, which require staff or consultants with relevant knowledge to support the health services area but do not indicate a specific staffing model. On one hand, this flexibility is helpful, as different programs have different needs, resources, and populations, and this gives programs the opportunity to hire health staff who they feel best meet the needs of the program. On the other hand, this results in a health manager workforce with diverse backgrounds in terms of education, experience, and skill set. Such significant differences in background, responsibilities, and training may result in a workforce that has varying skills and competencies across programs. At a minimum, our analyses suggest that there may be some differences in how the health services area is implemented as a result of differences in the health manager's background. While not explicitly examined in our study, such differences may also mean that children and families will have different experiences and may reap varying levels of health-related benefit from the program. OHS may wish to consider the merits of a core set of trainings to ensure a minimum, consistent level of knowledge and competencies in health managers across all HS/EHS programs.

The findings regarding health manager responsibilities and challenges could be used to inform program recruitment efforts when hiring a health manager and could assist with writing the health manager's job description. These findings also point to a potential need to consider how the health services area is staffed. A key challenge is that many health managers reported multiple responsibilities within their programs, above and beyond their duties with respect to the health services area. While the objective of this study was not to identify the "best" staffing model, health managers offered a number of staffing solutions that they felt would be more efficient and cost-effective. For example, several health managers noted that many of their duties are more administrative (e.g., paperwork, tracking), which perhaps could be handled by an administrator, saving money and freeing them up to directly address health needs and to encourage health promotion among children, families, and staff. Identifying creative staffing

solutions and empowering programs to adopt them would ensure that health managers' time is being effectively deployed.

Implications for Professional Development, Training, and Technical Assistance

Although opportunities for training and technical assistance are available at conferences and regional meetings, many health managers noted that their programs do not have the budget to support travel or participation in these meetings, which may lead to disparities in workforce knowledge and skills. There may be opportunities to facilitate linkages between health managers and the training and technical support provided by the OHS technical assistance system.

Health managers appreciate trainings that are online that they can access on demand, when schedules allow. At the same time, health managers and other staff often expressed frustration at the number of trainings and amount of general information available that lack actionable steps or concrete examples for how to translate that information into practice. Health managers noted in particular that actionable trainings on "how to be a health manager" and how to improve family engagement would be particularly helpful.

Beyond formal training and technical assistance from OHS and its national centers, there may be opportunities to support or encourage mentoring or networks between health managers of similar programs. Although some health managers reported regular contact with other health managers to share ideas and ask questions, others were working in isolation of other health managers and not regularly making those informal connections. Fostering connections between health managers may be particularly beneficial for the sharing of innovative ideas and lessons learned across programs, which may help fill the desire for more information on the actionable steps noted above.

Implications for the Health Management of Individual Children

Overall, programs use multiple strategies for managing the health care needs for the children they serve. Health managers noted that plans are put into effect at the earliest possible point, in most cases at enrollment, and reported working collaboratively with parents, providers, specialists, and staff to ensure that every child is safe and that any health care needs can be addressed. Health needs are not only met by health services area staff, however. The survey and interview data show, for example, that teachers play an important role in managing the day-to-day health of the children in their care. While teachers are given specialized training as needed to meet the needs of the children in their classrooms, some health managers and teachers reported that not all teachers feel comfortable with that type of responsibility.

Teachers are also heavily relied on to handle the day-to-day communication with families. While health managers and health staff oversee the health services area, they are not always on-site at the locations where children and families are served. As a result, health services staff may have fewer opportunities to interact with parents and to develop a positive rapport. The job of communicating to parents, therefore, often falls to the teachers, who are more likely to see the

parents or guardians during pick-up or drop-off, for example. While most are happy to do this, not all feel well equipped to speak with families about health issues that they know little about, and few feel adequately trained to address major barriers noted in this survey related to parent engagement: Some pparents do not see the value of the services that their children need, and parents are not open to discussing the issue.

Managing the health needs of children in Head Start is truly a joint effort that involves staff from the health services area and teachers and other staff who work more closely with children and families on a daily basis. Because of this, OHS may wish to consider training for teachers and other nonhealth staff on how to discuss sensitive health issues with families and how to ensure that families have the required knowledge and understanding of the Head Start health requirements.

Implications for Health Promotion

The selection and implementation of health-promotion activities within HS/EHS programs is quite varied. In some programs, the topics and activities were more prescriptive and given to teachers by health services area staff. In other programs, a general list of topics was expected to be covered over the course of the school year, but teachers had the flexibility to select when each topic would be covered and how it would be incorporated into the classroom. Most programs addressed common health promotion topics such as nutrition, physical activity, hygiene, safety and oral health but there was significant variation in the materials and resources that teachers used to introduce children to these topics. Although not required to do so, programs were using few evidenced-based curricula, which may reflect the availability of such curricula, as well as their use by programs when they are available. Instead programs were using a wide range of resources, which in many cases were developed by the program. Although there may be benefits to using less formal materials in the classroom—which often consisted of handouts or activities—the concern is that it is not clear how many of these resources have a demonstrated impact on the knowledge, activities, or behavior of the children and families to whom they are given.

Although health managers rely on numerous sources of information, finding evidence-based curricula can be quite difficult. OHS should identify or develop such curricula and to organize evidence-based resources in a centralized location, easily accessible by health managers and HS/EHS staff. In addition to being evidenced-based, however, attention should be paid to the training and resources required for implementation. For example, IMIL is a set of evidence-based tools supported by OHS to address obesity. Although many programs were using it, many were not, and of those who were using it, health managers expressed concerns with the fidelity of implementation. Programs noted that more training was needed (e.g., because of staff turnover), and that they did not always have the time or resources to implement it fully. This points to the need to identify or develop evidence-based curricula addressing key health promotion topics that could be easily implemented at low cost to HS/EHS programs. Development of such curricula, if

done well—for example, tailored to the population of children and families served in Head Start, aligned with other curricula used in the program, and supported with training and TA—could potentially contribute to a more consistent and higher standard of health-promotion activities across programs.

Implications for Community Linkages

Health managers are resourceful in leveraging community assets to support their programs. The majority of program representatives reported that they felt good about their community linkages and the ability of their partners to help them meet the needs of the children and families that they serve. Despite this relative success, about one-quarter of health managers reported that there is room for improvement with behavioral and mental health resources and, oral health resources. These are two unique areas of health that require tapping into a specialized population of providers. These specialties were also often cited needs for HSACs, suggesting that additional supports may be warranted to help programs build, strengthen, and maintain linkages with these providers. One challenge, however, is that in some areas, the lack of community support is not a reflection of the lack of interest but of limited provider availability. According to health manager interviews, the number of dentists who accept Medicaid, for example, is quite low in many regions. Health managers also reported a number of unique models or strategies that have been developed to overcome some of these challenges. Several programs in smaller or rural areas have come up with models whereby there is a single board that meets regularly and members serve as the advisory board for a range of programs in the town. This facilitates the sharing of information, and the same experts only have to attend one meeting rather than multiple. Another program asked departing HSAC members to assist with finding a replacement in order to maintain continuity on the committee. Finding ways to share innovative approaches and lessons learned may provide fresh ideas to health managers looking to further strengthen community engagement but faced with provider or volunteer burnout.

Implications for Health Services Area Requirements

Health managers were almost universal in voicing a clear and consistent tension between the time, resources, and staff they have working with them and the number of requirements they are obligated to meet. As noted in Chapter One (see also Appendix A), the health services area is governed by a set of Head Start performance standards. Some specify actions (e.g., screening, documentation) must be completed for every enrolled child in the program and, for some requirements, multiple times per year. Health managers also noted that in many cases the requirements are not clear. The ambiguous nature of some of the requirements may be adding to the workload of health managers, who reported spending time to research the requirements or perhaps doing more than is required because of a difference in interpretation. As a result of the time needed to meet performance standards, health managers reported that they do not have time to take on other health-related activities or pursuits they feel would be more beneficial to

children and families. There is also less time to devote to evaluating the effectiveness of prevention and health-promotion activities that are being undertaken in the classrooms.

Ideally, the Head Start performance standards in the health services area would ensure that HS/EHS programs deliver high-quality health-related services and are accountable for the services they deliver. The standards would provide health managers with clear guidance and expectations and allow health managers to use their time and expertise to maximize the health of the children and families in the programs. The revision of the Head Start performance standards, under way as of mid-2015 (Administration of Children and Families, 2015), provides an opportunity to revisit the standards and the associated requirements to ensure that they are clear and sufficiently well specified for health managers responsible for implementing them. For example, it may be possible to group the current requirements into must-haves (those requirements that are essential, core services that provide a direct health benefit to children) and nice-to-haves (those requirements that perhaps are not essential or that require more resources relative to the expected health benefit). Although program leadership at the local level is responsible for staffing and resource allocation, the reality is that there are limited resources. Given that many health managers reported that they do not have enough resources to effectively or efficiently meet all requirements, reviewing the standards to create a comprehensive set of must-have standards that are clearly stated could help align program resources with critical Head Start requirements.

The survey data indicate that many programs are satisfied with the relationships they have with health care providers and other partners. When discussing challenges during the more in-depth interviews, however, health managers reported that several of the most time-consuming requirements involve working with physician offices and convincing them of the need for medical tests and screens that physicians do not feel are necessary or appropriate. There may be ways in which OHS could offset some of the time and energy currently being taken up by health managers to address these challenges. Joint statements between OHS and the American Academy of Pediatrics, EPSDT, or state Medicaid offices may help to support health managers' efforts. Or perhaps staff from OHS national or regional offices can be on call to speak with providers who push back on requirements. The lack of alignment in some areas between EPSDT or Head Start requirements and standard pediatric practice deserves particular attention, as families are sometimes receiving conflicting information from trusted entities and are caught in the middle. Health managers reported feeling as if they are undermining or challenging physicians' abilities, which causes tension between the program and the clinical practice.

Implications for Head Start Messaging Regarding the Health Services Area

The health services area has been a central focus of Head Start from the program's inception, and the health-related performance standards exemplify the ongoing emphasis on physical, mental and behavioral, and oral health as core developmental priorities for participating children. Nevertheless, interviews with health managers revealed concern that the health services area is

perhaps a lower priority—reflected in budgets and staffing at the program level and messaging from OHS at the national level—as a result of the increased attention on school readiness in cognitive and social-emotional domains. Health managers' survey responses also indicated that some felt a lack of support from their program leadership or felt that their organizational culture did not prioritize health. Such perceptions, even if held by a small minority, can affect morale on the part of health managers and other staff.

Starting at the top, OHS could review its messaging regarding healthy child development to ensure that communications, training, and technical assistance clearly convey the importance of physical, mental and behavioral, and oral health as core building blocks for school readiness. That messaging can filter down to program directors, as well, who can then act to support health managers in their roles as they make decisions regarding budgets, staff, professional development, and so on. Responding to the implications already mentioned will also support the message that health matters.

Implications for the Role That Information Can Play Moving Forward

One particular challenge of this study was the identification of the health manager workforce. While information is available for the program director in the PIR, similar information is not collected about the health manager or other key staff relevant to the health services area. For this study, we worked with directors to identify their programs' health managers, but this type of intensive recruitment is not likely to be feasible for health-related studies in the future. Regularly collecting information about the health manager in the PIR—such as their name, contact information, formal education and training, years of experience, and the number of sites they oversee—will open the door for future research on the health services area and will allow for cost savings, because sampling frames could be developed based on program or health services area characteristics. Collecting this information also facilitates more-effective communication on the part of OHS, which could provide consistent messaging, resources, and training directly to the health manager workforce, without routing through directors or regional offices.

Another potentially useful source of information is the set of geocoded characteristics that were assembled for this study to link with survey response and PIR data. Such data provide a context for understanding, at a more localized level, the health-related needs, resources, challenges, and opportunities facing HS/EHS programs. The survey and interview responses indicated that some health managers already incorporate this type of information into their process of planning for and prioritizing the set of health services and activities they deliver. OHS should consider making such data more widely available for HS/EHS programs to utilize for planning, monitoring, and evaluation. Efforts could be made to identify additional geocoded data at an even finer level of geography, such as the location of specific types of health care providers or providers who accept Medicaid. The geocoded information could also be used by OHS to target training, technical assistance, and other resources to HS/EHS programs based on the local context within which they operate.

Conclusion

Despite significant differences across programs, health managers, overall, are a committed group of individuals who believe in the mission of Head Start and the value of the services they provide to children and their families. Health managers have seen firsthand the influence that they have had and shared numerous success stories illustrating ways in which HS/EHS staff—including teachers, family service workers, home visitors, nurses, and health managers—have made a positive difference in the health and lives of the children and families they serve. At the same time, health managers and other HS/EHS staff provided a wealth of information that has implications for the health services area moving forward. Findings from this study can help inform future training, technical assistance, staffing, policies, and research regarding the health services area, which collectively will have a meaningful and measurable effect on the health of children and families being served by HS/EHS programs.

Appendix A. Health-Related Head Start Program Performance Standards

This appendix includes a matrix with the 2014 Head Start Program Performance Standards that are most relevant for the health services area, including those pertaining to child health and safety (OHS, 2014). Table A.1 lists the reference for each standard and provides the associated text. The health-related standards appear throughout the Head Start Program Performance Standards and are not always colocated. This list was developed with input from OHS staff and staff from the Head Start National Center for Health.

Table A.1. Health-Related Health Start Program Performance Standards

Standard Reference	Standard Text
1301.31 Personnel Policies	
1301.31(e) Reporting child abuse or sexual abuse (p. 96)	Grantee and delegate agencies must develop a plan for responding to suspected or known child abuse or sexual abuse as defined in 45 CFR 1340.2(d) whether it occurs inside or outside of the program.
1304.20 Child Health and Development Services	
1304.20(a) Determining child health status (p. 121)	(1) In collaboration with the parents and as quickly as possible, but no later than 90 calendar days (with the exception noted in paragraph (a)(2) of this section) from the child's entry into the program (for the purposes of 45 CFR 1304.20(a)(1), 45 CFR 1304.20(a)(2), and 45 CFR 1304.20(b)(1), ''entry'' means the first day that Early Head Start or Head Start services are provided to the child), grantee and delegate agencies must: (i) Make a determination as to whether or not each child has an ongoing source of continuous, accessible health care. If a child does not have a source of ongoing health care, grantee and delegate agencies must assist the parents in accessing a source of care; (ii) Obtain from a health care professional a determination as to whether the child is up-to-date on a schedule of age appropriate preventive and primary health care which includes medical, dental and mental health. Such a schedule must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the State in which they operate, and the latest immunization recommendations issued by the Centers for Disease Control and Prevention, as well as any additional recommendations from the local Health Services Advisory Committee that are based on prevalent community health problems: (A) For children who are not up-to-date on an age-appropriate schedule of well child care, grantee and delegate agencies must assist parents in making the necessary arrangements to bring the child up-to-date; (B) For children who are up-to-date on an age-appropriate schedule of well child care, grantee and delegate agencies must ensure that they continue to follow the recommended schedule of well child care; and (C) Grantee and delegate agencies must establish procedures to track the provision of health care services. (iii) Obtain or arrange further diagnostic testing, examination, and treatment by an appropriate licensed or certified professional for each child with an observable, known or suspected health or developmental problem; and (iv) Develop and implement a follow-up plan for any condition identified in 45 CFR 1304.20(a)(1)(ii) and (iii) so that any needed treatment has begun. (2) Grantee and delegate agencies operating programs of shorter durations (90 days or less) must complete the above processes and those in 45 CFR 1304.20(b)(1) within 30 calendar days from the child's entry into the program.
1304.20(b) Screening for developmental, sensory, and behavioral concerns (p. 122)	(1) In collaboration with each child's parent, and within 45 calendar days of the child's entry into the program, grantee and delegate agencies must perform or obtain linguistically and age appropriate screening procedures to identify concerns regarding a child's developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual, and emotional skills (see 45 CFR 1308.6(b)(3) for additional information). To the greatest extent possible, these screening procedures must be sensitive to the child's cultural background. (2) Grantee and delegate agencies must obtain direct guidance from a mental health or child development professional on how to use the findings to address identified needs. (3) Grantee and delegate agencies must utilize multiple sources of information on all aspects of each child's development and behavior, including input from family members, teachers, and other relevant staff who are familiar with the child's typical behavior.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.20(c) Extended follow-up and treatment (p. 122)	(1) Grantee and delegate agencies must establish a system of ongoing communication with the parents of children with identified health needs to facilitate the implementation of the follow-up plan. (2) Grantee and delegate agencies must provide assistance to the parents, as needed, to enable them to learn how to obtain any prescribed medications, aids or equipment for medical and dental conditions. (3) Dental follow-up and treatment must include: (i) Fluoride supplements and topical fluoride treatments as recommended by dental professionals in communities where a lack of adequate fluoride levels has been determined or for every child with moderate to severe tooth decay; and (ii) Other necessary preventive measures and further dental treatment as recommended by the dental professional. (4) Grantee and delegate agencies must assist with the provision of related services addressing health concerns in accordance with the Individualized Education Program (IEP) and the Individualized Family Service Plan (IFSP). (5) Early Head Start and Head Start funds may be used for professional medical and dental services when no other source of funding is available. When Early Head Start or Head Start funds are used for such services, grantee and delegate agencies must have written documentation of their efforts to access other available sources of funding.
1304.20(d) Ongoing care (p. 123)	In addition to assuring children's participation in a schedule of well child care, as described in §1304.20(a) of this part, grantee and delegate agencies must implement ongoing procedures by which Early Head Start and Head Start staff can identify any new or recurring medical, dental, or developmental concerns so that they may quickly make appropriate referrals. These procedures must include: periodic observations and recordings, as appropriate, of individual children's developmental progress, changes in physical appearance (e.g., signs of injury or illness) and emotional and behavioral patterns. In addition, these procedures must include observations from parents and staff.
1304.20(e) Involving parents (p. 123)	In conducting the process, as described in §§1304.20 (a), (b), and (c), and in making all possible efforts to ensure that each child is enrolled in and receiving appropriate health care services, grantee and delegate agencies must: (1) Consult with parents immediately when child health or developmental problems are suspected or identified; (2) Familiarize parents with the use of and rationale for all health and developmental procedures administered through the program or by contract or agreement, and obtain advance parent or guardian authorization for such procedures. Grantee and delegate agencies also must ensure that the results of diagnostic and treatment procedures and ongoing care are shared with and understood by the parents; (3) Talk with parents about how to familiarize their children in a developmentally appropriate way and in advance about all of the procedures they will receive while enrolled in the program; (4) Assist parents in accordance with 45 CFR 1304.40(f)(2) (i) and (ii) to enroll and participate in a system of ongoing family health care and encourage parents to be active partners in their children's health care process; and (5) If a parent or other legally responsible adult refuses to give authorization for health services, grantee and delegate agencies must maintain written documentation of the refusal.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.20(f) Individualization of the program (p. 123)	(1) Grantee and delegate agencies must use the information from the screening for developmental, sensory, and behavioral concerns, the ongoing observations, medical and dental evaluations and treatments, and insights from the child's parents to help staff and parents determine how the program can best respond to each child's individual characteristics, strengths and needs. (2) To support individualization for children with disabilities in their programs, grantee and delegate agencies must assure that: (i) Services for infants and toddlers with disabilities and their families support the attainment of the expected outcomes contained in the Individualized Family Service Plan (IFSP) for children identified under the infants and toddlers with disabilities program (Part H) of the Individuals with Disabilities Education Act, as implemented by their State or Tribal government; for preschool age children with disabilities, consistent with the requirements of 45 CFR 1308.19. (ii) Enrolled families with infants and toddlers suspected of having a disability are promptly referred to the local early intervention agency designated by the State Part H plan to coordinate any needed evaluations, determine eligibility for Part H services, and coordinate the development of an IFSP for children determined to be eligible under the guidelines of that State's program. Grantee and delegate agencies must support parent participation in the evaluation and IFSP development process for infants and toddlers enrolled in their program; (iii) They participate in and support efforts for a smooth and effective transition for children who, at age three, will need to be considered for services for preschool age children with disabilities; and (iv) They participate in the development and implementation of the Individualized Education Program (IEP).
1304.21 Education and Early Childhood Development	
1304.21(a) Child development and education approach for all children (p. 124)	(1) In order to help children gain the skills and confidence necessary to be prepared to succeed in their present environment and with later responsibilities in school and life, grantee and delegate agencies' approach to child development and education must: (i) Be developmentally and linguistically appropriate, recognizing that children have individual rates of development as well as individual interests, temperaments, languages, cultural backgrounds, and learning styles; (ii) Be inclusive of children with disabilities, consistent with their Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) (see 45 CFR 1308.19); (iii) Provide an environment of acceptance that supports and respects gender, culture, language, ethnicity and family composition; (iv) Provide a balanced daily program of child-initiated and adult-directed activities, including individual and small group activities; and (v) Allow and enable children to independently use toilet facilities when it is developmentally appropriate and when efforts to encourage toilet training are supported by the parents. (2) Parents must be: (i) Invited to become integrally involved in the development of the program's curriculum and approach to child development and education; (ii) Provided opportunities to increase their child observation skills and to share assessments with staff that will help plan the learning experiences; and (iii) Encouraged to participate in staff-parent conferences and home visits to discuss their child's development 45 CFR Ch. XIII (10–1–14 Edition) and education (see 45 CFR 1304.40(e)(4) and 45 CFR 1304.40(i)(2)).

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.21(a), continued	(3) Grantee and delegate agencies must support social and emotional development by: (i) Encouraging development which enhances each child's strengths by: (A) Building trust; (B) Fostering independence; (C) Encouraging self-control by setting clear, consistent limits, and having realistic expectations; (D) Encouraging respect for the feelings and rights of others; and (E) Supporting and respecting the home language, culture, and family composition of each child in ways that support the child's health and wellbeing; and (ii) Planning for routines and transitions so that they occur in a timely, predictable and unrushed manner according to each child's needs. (4) Grantee and delegate agencies must provide for the development of each child's cognitive and language skills by: (i) Supporting each child's learning, using various strategies including experimentation, inquiry, observation, play and exploration; (ii) Ensuring opportunities for creative self-expression through activities such as art, music, movement, and dialogue; (iii) Promoting interaction and language use among children and between children and adults; and (iv) Supporting emerging literacy and numeracy development through materials and activities according to the developmental level of each child. (5) In center-based settings, grantee and delegate agencies must promote each child's physical development by: (i) Providing sufficient time, indoor and outdoor space, equipment, materials and adult guidance for active play and movement that support the development of gross motor skills; (ii) Providing appropriate time, space, equipment, materials and adult guidance for the development of fine motor skills according to each child's developmental level; and (iii) Providing an appropriate environment and adult guidance for the participation of children with special needs. (6) In home-based settings, grantee and delegate agencies must encourage parents to appreciate the importance of physical development, provide opportunities for children's outdoor and indoor active play, and guide children in the safe use of equipment and materials.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.21(b) Child development and education approach for infants and toddlers (p. 125)	(1) Grantee and delegate agencies' program of services for infants and toddlers must encourage (see 45 CFR 1304.3(a)(5) for a definition of curriculum): (i) The development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time. Teachers must demonstrate an understanding of the child's family culture and, whenever possible, speak the child's language (see 45 CFR 1304.52(g)(2)); (ii) Trust and emotional security so that each child can explore the environment according to his or her developmental level; and (iii) Opportunities for each child to explore a variety of sensory and motor experiences with support and stimulation from teachers and family members. (2) Grantee and delegate agencies must support the social and emotional development of infants and toddlers by promoting an environment that: (i) Encourages the development of self-awareness, autonomy, and self-expression; and (ii) Supports the emerging communication skills of infants and toddlers by providing daily opportunities for each child to interact with others and to express himself or herself freely. (3) Grantee and delegate agencies must promote the physical development of infants and toddlers by: (i) Supporting the development of the physical skills of infants and toddlers including gross motor skills, such as grasping, pulling, pushing, crawling, walking, and climbing; and (ii) Creating opportunities for fine motor development that encourage the control and coordination of small, specialized motions, using the eyes, mouth, hands, and feet.
1304.21(c) Child development and education approach for preschoolers (p. 125)	(1) Grantee and delegate agencies, in collaboration with the parents, must implement a curriculum (see 45 CFR 1304.3(a)(5)) that: (i) Supports each child's individual pattern of development and learning; (ii) Provides for the development of cognitive skills by encouraging each child to organize his or her experiences, to understand concepts, and to develop age appropriate literacy, numeracy, reasoning, problem solving and decision-making skills which form a foundation for school readiness and later school success; (iii) Integrates all educational aspects of the health, nutrition, and mental health services into program activities; (iv) Ensures that the program environment helps children develop emotional security and facility in social relationships; (v) Enhances each child's understanding of self as an individual and as a member of a group; (vi) Provides each child with opportunities for success to help develop feelings of competence, self-esteem, and positive attitudes toward learning; and (vii) Provides individual and small group experiences both indoors and outdoors. (2) Staff must use a variety of strategies to promote and support children's learning and developmental progress based on the observations and ongoing assessment of each child (see 45 CFR 1304.20(b), 1304.20(d), and 1304.20(e)). [61 CFR 57210, Nov. 5, 1996, as amended at 63 FR 2313, Jan. 15, 1998]

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.22 Child Health and Safety	
1304.22(a) Health emergency procedures (p. 125)	Grantee and delegate agencies operating center-based programs must establish and implement policies and procedures to respond to medical and dental health emergencies with which all staff are familiar and trained. At a minimum, these policies and procedures must include: (1) Posted policies and plans of action for emergencies that require rapid response on the part of staff (e.g., a child choking) or immediate medical or dental attention; (2) Posted locations and telephone numbers of emergency response systems. Up-to-date family contact information and authorization for emergency care for each child must be readily available; (3) Posted emergency evacuation routes and other safety procedures for emergencies (e.g., fire or weather-related) which are practiced regularly (see 45 CFR 1304.53 for additional information); (4) Methods of notifying parents in the event of an emergency involving their child; and (5) Established methods for handling cases of suspected or known child abuse and neglect that are in compliance with applicable Federal, State, or Tribal laws.
1304.22(b) Conditions of short-term exclusion and admittance (p. 126)	(1) Grantee and delegate agencies must temporarily exclude a child with a short-term injury or an acute or short-term contagious illness, that cannot be readily accommodated, from program participation in center-based activities or group experiences, but only for that generally short-term period when keeping the child in care poses a significant risk to the health or safety of the child or anyone in contact with the child. (2) Grantee and delegate agencies must not deny program admission to any child, nor exclude any enrolled child from program participation for a long-term period, solely on the basis of his or her health care needs or medication requirements unless keeping the child in care poses a significant risk to the health or safety of the child or anyone in contact with the child and the risk cannot be eliminated or reduced to an acceptable level through reasonable modifications in the grantee or delegate agency's policies, practices or procedures or by providing appropriate auxiliary aids which would enable the child to participate without fundamentally altering the nature of the program. (3) Grantee and delegate agencies must request that parents inform them of any health or safety needs of the child that the program may be required to address. Programs must share information, as necessary, with appropriate staff regarding accommodations needed in accordance with the program's confidentiality policy.
1304.22(c) Medication administration (p. 126)	Grantee and delegate agencies must establish and maintain written procedures regarding the administration, handling, and storage of medication for every child. Grantee and delegate agencies may modify these procedures as necessary to satisfy State or Tribal laws, but only where such laws are consistent with Federal laws. The procedures must include: (1) Labeling and storing, under lock and key, and refrigerating, if necessary, all medications, including those required for staff and volunteers; (2) Designating a trained staff member(s) or school nurse to administer, handle and store child medications; (3) Obtaining physicians' instructions and written parent or guardian authorizations for all medications administered by staff; (4) Maintaining an individual record of all medications dispensed, and reviewing the record regularly with the child's parents; (5) Recording changes in a child's behavior that have implications for drug dosage or type, and assisting parents in communicating with their physician regarding the effect of the medication on the child; and (6) Ensuring that appropriate staff members can demonstrate proper techniques for administering, handling, and storing medication, including the use of any necessary equipment to administer medication.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.22(d) Injury prevention (p. 126)	Grantee and delegate agencies must: (1) Ensure that staff and volunteers can demonstrate safety practices; and (2) Foster safety awareness among children and parents by incorporating it into child and parent activities
1304.22 (e) Hygiene (p. 126)	(1) Staff, volunteers, and children must wash their hands with soap and running water at least at the following times: (i) After diapering or toilet use; (ii) Before food preparation, handling, consumption, or any other food related activity (e.g., setting the table); (iii) Whenever hands are contaminated with blood or other bodily fluids; and (iv) After handling pets or other animals. (2) Staff and volunteers must also wash their hands with soap and running water: (i) Before and after giving medications; (ii) Before and after treating or bandaging a wound (nonporous gloves should be worn if there is contact with blood or blood-containing body fluids); and (iii) After assisting a child with toilet use. (3) Nonporous (e.g., latex) gloves must be worn by staff when they are in contact with spills of blood or other visibly bloody bodily fluids. (4) Spills of bodily fluids (e.g., urine, feces, blood, saliva, nasal discharge, eye discharge or any fluid discharge) must be cleaned and disinfected immediately in keeping with professionally established guidelines (e.g., standards of the Occupational Safety Health Administration, U.S. Department of Labor). Any tools and equipment used to clean spills of bodily fluids must be cleaned and disinfected immediately. Other blood-contaminated materials must be disposed of in a plastic bag with a secure tie. (5) Grantee and delegate agencies must adopt sanitation and hygiene procedures for diapering that adequately protect the health and safety of children served by the program and staff. Grantee and delegate agencies must ensure that staff properly conduct these procedures. (6) Potties that are utilized in a center-based program must be emptied into the toilet and cleaned and disinfected after each use in a utility sink used for this purpose. (7) Grantee and delegate agencies operating programs for infants and toddlers must space cribs and cots at least three feet apart to avoid spreading contagious illness and to allow for easy access to each child.
1304.22(f) First aid kits (p. 127)	(1) Readily available, well-supplied first aid kits appropriate for the ages served and the program size must be maintained at each facility and available on outings away from the site. Each kit must be accessible to staff members at all times, but must be kept out of the reach of children. (2) First aid kits must be restocked after use, and an inventory must be conducted at regular intervals.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
	1304.23 Child Nutrition
1304.23(a) Identification of nutritional needs (p. 127)	Staff and families must work together to identify each child's nutritional needs, taking into account staff and family discussions concerning: (1) Any relevant nutrition-related assessment data (height, weight, hemoglobin/hematocrit) obtained under 45 CFR 1304.20(a); (2) Information about family eating patterns, including cultural preferences, special dietary requirements for each child with nutrition-related health problems, and the feeding requirements of infants and toddlers and each child with disabilities (see 45 CFR 1308.20); (3) For infants and toddlers, current feeding schedules and amounts and types of food provided, including whether breast milk or formula and baby food is used; meal patterns; new foods introduced; food intolerances and preferences; voiding patterns; and observations related to developmental changes in feeding and nutrition. This information must be shared with parents and updated regularly; and (4) Information about major community nutritional issues, as identified through the Community Assessment or by the Health Services Advisory Committee or the local health department.
1304.23(b) Nutritional services (p. 128)	(1) Grantee and delegate agencies must design and implement a nutrition program that meets the nutritional needs and feeding requirements of each child, including those with special dietary needs and children with disabilities. Also, the nutrition program must serve a variety of foods which consider cultural and ethnic preferences and which broaden the child's food experience. (i) All Early Head Start and Head Start grantee and delegate agencies must use funds from USDA Food and Consumer Services Child Nutrition Programs as the primary source of payment for meal services. Early Head Start and Head Start funds may be used to cover those allowable costs not covered by the USDA. (ii) Each child in a part-day center-based setting must receive meals and snacks that provide at least 1/3 of the child's daily nutritional needs. Each child in a center-based full-day program must receive meals and snacks that provide 1/2 to 2/3 of the child's daily nutritional needs, depending upon the length of the program day. (iii) All children in morning center-based settings who have not received breakfast at the time they arrive at the Early Head Start or Head Start program must be served a nourishing breakfast. (iv) Each infant and toddler in center-based settings must receive food appropriate to his or her nutritional needs, developmental readiness, and feeding skills, as recommended in the USDA meal pattern or nutrient standard menu planning requirements outlined in 7 CFR parts 210, 220, and 226. (v) For 3- to 5-year-olds in center-based settings, the quantities and kinds of food served must conform to recommended serving sizes and minimum standards for meal patterns recommended in the USDA meal pattern or nutrient standard menu planning requirements outlined in 7 CFR parts 210, 220, and 226. (vi) For 3- to 5-year-olds in center-based settings or other Head Start group experiences, foods served must be high in nutrients and low in fat, sugar, and salt. (vii) Meal and snack periods in center-based settings must be appropriately scheduled and adjusted, where necessary, to ensure that individual needs are met. Infants and young toddlers who need it must be fed "on demand" to the extent possible or at appropriate intervals. (2) Grantee and delegate agencies operating home-based program options must provide appropriate snacks and meals to each child during group socialization activities (see 45 CFR 1306.33 for information regarding home-based group socialization). (3) Staff must promote effective dental hygiene among children in conjunction with meals. (4) Parents and appropriate community agencies must be involved in planning, implementing, and evaluating the agencies' nutritional services.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.23(c) Meal service (p. 128)	Grantee and delegate agencies must ensure that nutritional services in center-based settings contribute to the development and socialization of enrolled children by providing that: (1) A variety of food is served which broadens each child's food experiences; (2) Food is not used as punishment or reward, and that each child is encouraged, but not forced, to eat or taste his or her food; (3) Sufficient time is allowed for each child to eat; (4) All toddlers and preschool children and assigned classroom staff, including volunteers, eat together family style and share the same menu to the extent possible; (5) Infants are held while being fed and are not laid down to sleep with a bottle; (6) Medically-based diets or other dietary requirements are accommodated; and (7) As developmentally appropriate, opportunity is provided for the involvement of children in food-related activities.
1304.23(d) Family assistance with nutrition (p. 128)	Parent education activities must include opportunities to assist individual families with food preparation and nutritional skills.
1304.23(e) Food safety and sanitation (p. 128)	(1) Grantee and delegate agencies must post evidence of compliance with all applicable Federal, State, Tribal, and local food safety and sanitation laws, including those related to the storage, preparation and service of food and the health of food handlers. In addition, agencies must contract only with food service vendors that are licensed in accordance with State, Tribal or local laws. (2) For programs serving infants and toddlers, facilities must be available for the proper storage and handling of breast milk and formula.
	1304.24 Child Mental Health
1304.24(a) Mental health services (p. 129)	(1) Grantee and delegate agencies must work collaboratively with parents (see 45 CFR 1304.40(f) for issues related to parent education) by: (i) Soliciting parental information, observations, and concerns about their child's mental health; (ii) Sharing staff observations of their child and discussing and anticipating with parents their child's behavior and development, including separation and attachment issues; (iii) Discussing and identifying with parents appropriate responses to their child's behaviors; (iv) Discussing how to strengthen nurturing, supportive environments and relationships in the home and at the program; (v) Helping parents to better understand mental health issues; and (vi) Supporting parents' participation in any needed mental health interventions. (2) Grantee and delegate agencies must secure the services of mental health professionals on a schedule of sufficient frequency to enable the timely and effective identification of and intervention in family and staff concerns about a child's mental health; and (3) Mental health program services must include a regular schedule of onsite mental health consultation involving the mental health professional, program staff, and parents on how to: (i) Design and implement program practices responsive to the identified behavioral and mental health concerns of an individual child or group of children; (ii) Promote children's mental wellness by providing group and individual staff and parent education on mental health issues; (iii) Assist in providing special help for children with atypical behavior or development; and (iv) Utilize other community mental health resources, as needed.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
	1304.40 Family Partnerships
1304.40(b) Accessing community services and resources (p. 130)	(1) Grantee and delegate agencies must work collaboratively with all participating parents to identify and continually access, either directly or through referrals, services and resources that are responsive to each family's interests and goals, including: (i) Emergency or crisis assistance in areas such as food, housing, clothing, and transportation; (ii) Education and other appropriate interventions, including opportunities for parents to participate in counseling programs or to receive information on mental health issues that place families at risk, such as substance abuse, child abuse and neglect, and domestic violence; and (iii) Opportunities for continuing education and employment training and other employment services through formal and informal networks in the community. (2) Grantee and delegate agencies must follow-up with each family to determine whether the kind, quality, and timeliness of the services received through referrals met the families' expectations and circumstances.
1304.40(c) Services to pregnant women who are enrolled in programs serving pregnant women, infants, and toddlers (p. 130)	(1) Early Head Start grantee and delegate agencies must assist pregnant women to access comprehensive prenatal and postpartum care, through referrals, immediately after enrollment in the program. This care must include: (i) Early and continuing risk assessments, which include an assessment of nutritional status as well as nutrition counseling and food assistance, if necessary; (ii) Health promotion and treatment, including medical and dental examinations on a schedule deemed appropriate by the attending health care providers as early in the pregnancy as possible; and (iii) Mental health interventions and follow-up, including substance abuse prevention and treatment services, as needed. (2) Grantee and delegate agencies must provide pregnant women and other family members, as appropriate, with prenatal education on fetal development (including risks from smoking and alcohol), labor and delivery, and postpartum recovery (including maternal depression). (3) Grantee and delegate agencies must provide information on the benefits of breast feeding to all pregnant and nursing mothers. For those who choose to breast feed in center-based programs, arrangements must be provided as necessary.
1304.40(e) Parental involvement in child development and education (p. 130)	(3) Grantee and delegate agencies must provide opportunities for parents to enhance their parenting skills, knowledge, and understanding of the educational and developmental needs and activities of their children and to share concerns about their children with program staff (see 45 CFR 1304.21 for additional requirements related to parent involvement).
1304.40(f) Parent involvement in health, nutrition, and mental health education (p. 131)	(1) Grantee and delegate agencies must provide medical, dental, nutrition, and mental health education programs for program staff, parents, and families. (2) Grantee and delegate agencies must ensure that, at a minimum, the medical and dental health education program: (i) Assists parents in understanding how to enroll and participate in a system of ongoing family health care. (ii) Encourages parents to become active partners in their children's medical and dental health care process and to accompany their child to medical and dental examinations and appointments; and (iii) Provides parents with the opportunity to learn the principles of preventive medical and dental health, emergency first-aid, occupational and environmental hazards, and safety practices for use in the classroom and in the home. In addition to information on general topics (e.g., maternal and child health and the prevention of Sudden Infant Death Syndrome), information specific to the health needs of individual children must also be made available to the extent possible.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.40(f), continued	(3) Grantee and delegate agencies must ensure that the nutrition education program includes, at a minimum: (i) Nutrition education in the selection and preparation of foods to meet family needs and in the management of food budgets; and (ii) Parent discussions with program staff about the nutritional status of their child. (4) Grantee and delegate agencies must ensure that the mental health education program provides, at a minimum (see 45 CFR 1304.24 for issues related to mental health education): (i) A variety of group opportunities for parents and program staff to identify and discuss issues related to child mental health; (ii) Individual opportunities for parents to discuss mental health issues related to their child and family with program staff; and (iii) The active involvement of parents in planning and implementing any mental health interventions for their children.
1304.40(g) Parent involvement in community advocacy (p. 131)	(1) Grantee and delegate agencies must: (i) Support and encourage parents to influence the character and goals of community services in order to make them more responsive to their interests and needs; and (ii) Establish procedures to provide families with comprehensive information about community resources (see 45 CFR 1304.41(a)(2) for additional requirements). (2) Parents must be provided regular opportunities to work together, and with other community members, on activities that they have helped develop and in which they have expressed an interest.
1304.40(i) Parent involvement in home visits (p. 132)	(1) Grantee and delegate agencies must not require that parents permit home visits as a condition of the child's participation in Early Head Start or Head Start center-based program options. Every effort must be made to explain the advantages of home visits to the parents. (2) The child's teacher in center-based programs must make no less than two home visits per program year to the home of each enrolled child, unless the parents expressly forbid such visits, in accordance with the requirements of 45 CFR 1306.32(b)(8). Other staff working with the family must make or join home visits, as appropriate. (3) Grantee and delegate agencies must schedule home visits at times that are mutually convenient for the parents or primary caregivers and staff. (4) In cases where parents whose children are enrolled in the center-based program option ask that the home visits be conducted outside the home, or in cases where a visit to the home presents significant safety hazards for staff, the home visit may take place at an Early Head Start or Head Start site or at another safe location that affords privacy. Home visits in home-based program options must be conducted in the family's home. (See 45 CFR 1306.33 regarding the home-based program option.) (5) In addition, grantee and delegate agencies operating home-based program options must meet the requirements of 45 CFR 1306.33(a)(1) regarding home visits. (6) Grantee and delegate agencies serving infants and toddlers must arrange for health staff to visit each newborn within two weeks after the infant's birth to ensure the well-being of both the mother and the child.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.41 Community Partnerships	
1304.41(a) Partnerships (p. 132)	(1) Grantee and delegate agencies must take an active role in community planning to encourage strong communication, cooperation, and the sharing of information among agencies and their community partners and to improve the delivery of community services to children and families in accordance with the agency's confidentiality policies. Documentation must be maintained to reflect the level of effort undertaken to establish community partnerships (see 45 CFR 1304.51 for additional planning requirements). (2) Grantee and delegate agencies must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs, and to ensure that Early Head Start and Head Start programs respond to community needs, including: (i) Health care providers, such as clinics, physicians, dentists, and other health professionals; (ii) Mental health providers; (iii) Nutritional service providers; (iv) Individuals and agencies that provide services to children with disabilities and their families (see 45 CFR 1308.4 for specific service requirements); (v) Family preservation and support services; (vi) Child protective services and any other agency to which child abuse must be reported under State or Tribal law; (vii) Local elementary schools and other educational and cultural institutions, such as libraries and museums, for both children and families; (viii) Providers of child care services; and (ix) Any other organizations or businesses that may provide support and resources to families. (3) Grantee and delegate agencies must perform outreach to encourage volunteers from the community to participate in Early Head Start and Head Start programs. (4) To enable the effective participation of children with disabilities and their families, grantee and delegate agencies must make specific efforts to develop interagency agreements with local education agencies (LEAs) and other agencies within the grantee and delegate agency's service area (see 45 CFR 1308.4(h) for specific requirements concerning interagency agreements).
1304.41(b) Advisory committees (p. 133)	Each grantee directly operating an Early Head Start or Head Start program, and each delegate agency, must establish and maintain a Health Services Advisory Committee which includes Head Start parents, professionals, and other volunteers from the community. Grantee and delegate agencies also must establish and maintain such other service advisory committees as they deem appropriate to address program service issues such as community partnerships and to help agencies respond to community needs.
1304.41(c) Transition services (p. 133)	(1) Grantee and delegate agencies must establish and maintain procedures to support successful transitions for enrolled children and families from previous child care programs into Early Head Start or Head Start and from Head Start into elementary school, a Title I of the Elementary and Secondary Education Act preschool program, or other child care settings. These procedures must include: (i) Coordinating with the schools or other agencies to ensure that individual Early Head Start or Head Start children's relevant records are transferred to the school or next placement in which a child ill enroll or from earlier placements to Early Head Start or Head Start; (ii) Outreach to encourage communication between Early Head Start or Head Start staff and their counterparts in the schools and other child care settings including principals, teachers, social workers and health staff to facilitate continuity of programming; (iii) Initiating meetings involving Head Start teachers and parents and kindergarten or elementary school teachers to discuss the developmental progress and abilities of individual children; and (iv) Initiating joint transition-related training for Early Head Start or Head Start staff and school or other child development staff.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.41(c), continued	(2) To ensure the most appropriate placement and services following participation in Early Head Start, transition planning must be undertaken for each child and family at least six months prior to the child's third birthday. The process must take into account: The child's health status and developmental level, progress made by the child and family while in Early Head Start, current and changing family circumstances, and the availability of Head Start and other child development or child care services in the community. As appropriate, a child may remain in Early Head Start, following his or her third birthday, for additional months until he or she can transition into Head Start or another program. (3) See 45 CFR 1304.40(h) for additional requirements related to parental participation in their child's transition to and from Early Head Start or Head Start.
	1304.51 Management Systems and Procedures
1304.51(a) Program planning (p. 138)	(1) Grantee and delegate agencies must develop and implement a systematic, ongoing process of program planning that includes consultation with the program's governing body, policy groups, and program staff, and with other community organizations that serve Early Head Start and Head Start or other low-income families with young children. Program planning must include: (i) An assessment of community strengths, needs and resources through completion of the Community Assessment, in accordance with the requirements of 45 CFR 1305.3; (ii) The formulation of both multiyear (long-range) program goals and short-term program and financial objectives that address the findings of the Community Assessment, are consistent with the philosophy of Early Head Start and Head Start, and reflect the findings of the program's annual self assessment; and (iii) The development of written plan(s) for implementing services in each of the program areas covered by this part (e.g., Early Childhood Development and Health Services, Family and Community Partnerships, and Program Design and Management). See the requirements of 45 CFR parts 1305, 1306, and 1308. (2) All written plans for implementing services, and the progress in meeting them, must be reviewed by the grantee or delegate agency staff and reviewed and approved by the Policy Council or Policy Committee at least annually, and must be revised and updated as needed.
1304.51(b) Communications–general (p. 139)	Grantee and delegate agencies must establish and implement systems to ensure that timely and accurate information is provided to parents, policy groups, staff, and the general community.
1304.51(c) Communications with families (p. 139)	(1) Grantee and delegate agencies must ensure that effective two-way comprehensive communications between staff and parents are carried out on a regular basis throughout the program year. (2) Communication with parents must be carried out in the parents' primary or preferred language or through an interpreter, to the extent feasible.
1304.51(d) Communications with governing bodies and policy groups (p. 139)	Grantee and delegate agencies must ensure that the following information is provided regularly to their grantee and delegate governing bodies and to members of their policy groups: (1) Procedures and timetables for program planning; (2) Policies, guidelines, and other communications from HHS; (3) Program and financial reports; and (4) Program plans, policies, procedures, and Early Head Start and Head Start grant applications.
1304.51(e) Communications among staff (p. 139)	Grantee and delegate agencies must have mechanisms for regular communication among all program staff to facilitate quality outcomes for children and families.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.51(g) Record-keeping systems (p. 139)	Grantee and delegate agencies must establish and maintain efficient and effective record-keeping systems to provide accurate and timely information regarding children, families, and staff and must ensure appropriate confidentiality of this information.
1304.51(h) Reporting systems (p. 139)	Grantee and delegate agencies must establish and maintain efficient and effective reporting systems that: (1) Generate periodic reports of financial status and program operations in order to control program quality, maintain program accountability, and advise governing bodies, policy groups, and staff of program progress; and (2) Generate official reports for Federal, State, and local authorities, as required by applicable law.
1304.51(i) Program self-assessment and monitoring (p. 138)	(1) At least once each program year, with the consultation and participation of the policy groups and, as appropriate, other community members, grantee and delegate agencies must conduct a self-assessment of their effectiveness and progress in meeting program goals and objectives and in implementing Federal regulations. (2) Grantees must establish and implement procedures for the ongoing monitoring of their own Early Head Start and Head Start operations, as well as those of each of their delegate agencies, to ensure that these operations effectively implement Federal regulations.
	1304.52 Human Resources Management
1304.52(a) Organizational structure (p. 140)	(1) Grantee and delegate agencies must establish and maintain an organizational structure that supports the accomplishment of program objectives. This structure must address the major functions and responsibilities assigned to each staff position and must provide evidence of adequate mechanisms for staff supervision and support. (2) At a minimum, grantee and delegate agencies must ensure that the following program management functions are formally assigned to and adopted by staff within the program: (i) Program management (the Early Head Start or Head Start director); (ii) Management of early childhood development and health services, including child development and education; child medical, dental, and mental health; child nutrition; and, services for children with disabilities; and (iii) Management of family and community partnerships, including parent activities.
1304.52(d) Qualifications of content area experts (p. 140)	Grantee and delegate agencies must hire staff or consultants who meet the qualifications listed below to provide content area expertise and oversight on an ongoing or regularly scheduled basis. Agencies must determine the appropriate staffing pattern necessary to provide these functions. (1) Education and child development services must be supported by staff or consultants with training and experience in areas that include: The theories and principles of child growth and development, early childhood education, and family support. In addition, staff or consultants must meet the qualifications for classroom teachers, as specified in section 648A of the Head Start Act and any subsequent amendments regarding the qualifications of teachers. (2) Health services must be supported by staff or consultants with training and experience in public health, nursing, health education, maternal and child health, or health administration. In addition, when a health procedure must be performed only by a licensed/ certified health professional, the agency must assure that the requirement is followed. (3) Nutrition services must be supported by staff or consultants who are registered dietitians or nutritionists. (4) Mental health services must be supported by staff or consultants who are licensed or certified mental health professionals with experience and expertise in serving young children and their families. (5) Family and community partnership services must be supported by staff or consultants with training and experience in field(s) related to social, human, or family services.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.52(d), continued	(6) Parent involvement services must be supported by staff or consultants with training, experience, and skills in assisting the parents of young children in advocating and decision-making for their families. (7) Disabilities services must be supported by staff or consultants with training and experience in securing and individualizing needed services for children with disabilities. (8) Grantee and delegate agencies must secure the regularly scheduled or ongoing services of a qualified fiscal officer.
1304.52(e) Home visitor qualifications (p. 141)	Home visitors must have knowledge and experience in child development and early childhood education; the principles of child health, safety, and nutrition; adult learning principles; and family dynamics. They must be skilled in communicating with and motivating people. In addition, they must have knowledge of community resources and the skills to link families with appropriate agencies and services.
1304.52(f) Infant and toddler staff qualifications (p. 141)	Early Head Start and Head Start staff working as teachers with infants and toddlers must obtain a Child Development Associate (CDA) credential for Infant and Toddler Caregivers or an equivalent credential that addresses comparable competencies within one year of the effective date of the final rule or, thereafter, within one year of hire as a teacher of infants and toddlers. In addition, infants and toddler teachers must have the training and experience necessary to develop consistent, stable, and supportive relationships with very young children. The training must develop knowledge of infant and toddler development, safety issues in infant and toddler care (e.g., reducing the risk of Sudden Infant Death Syndrome), and methods for communicating effectively with infants and toddlers, their parents, and other staff members.
1304.52(g) Classroom staffing and home visitors (p. 141)	(1) Grantee and delegate agencies must meet the requirements of 45 CFR 1306.20 regarding classroom staffing. (2) When a majority of children speak the same language, at least one classroom staff member or home visitor interacting regularly with the children must speak their language. (3) For center-based programs, the class size requirements specified in 45 CFR 1306.32 must be maintained through the provision of substitutes when regular classroom staff are absent. (4) Grantee and delegate agencies must ensure that each teacher working exclusively with infants and toddlers has responsibility for no more than four infants and toddlers and that no more than eight infants and toddlers are placed in any one group. However, if State, Tribal or local regulations specify staff:child ratios and group sizes more stringent than this requirement, the State, Tribal or local regulations must apply. (5) Staff must supervise the outdoor and indoor play areas in such a way that children's safety can be easily monitored and ensured.
1304.52(h) Family child care providers (p. 141)	(3) Grantee and delegate agencies offering the family child care option must ensure that closures of the family child care setting for reasons of emergency are minimized and that providers work with parents to establish alternate plans when emergencies do occur. Grantees and delegates must also ensure that the family child care home advises parents of planned closures due to vacation, routine maintenance, or other reason well in advance.
1304.52(i) Standards of conduct (p. 142)	(1) Grantee and delegate agencies must ensure that all staff, consultants, and volunteers abide by the program's standards of conduct. These standards must specify that: (i) They will respect and promote the unique identity of each child and family and refrain from stereotyping on the basis of gender, race, ethnicity, culture, religion, or disability; (ii) They will follow program confidentiality policies concerning information about children, families, and other staff members; (iii) No child will be left alone or unsupervised while under their care; and (iv) They will use positive methods of child guidance and will not engage in corporal punishment, emotional or physical abuse, or humiliation. In addition, they will not employ methods of discipline that involve isolation, the use of food as punishment or reward, or the denial of basic needs.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.52(i), continued	(2) Grantee and delegate agencies must ensure that all employees engaged in the award and administration of contracts or other financial awards sign statements that they will not solicit or accept personal gratuities, favors, or anything of significant monetary value from contractors or potential contractors. (3) Personnel policies and procedures must include provision for appropriate penalties for violating the standards of conduct.
1304.52(k) Staff and volunteer health (p. 142)	(1) Grantee and delegate agencies must assure that each staff member has an initial health examination (that includes screening for tuberculosis) and a periodic re-examination (as recommended by their health care provider or as mandated by State, Tribal, or local laws) so as to assure that they do not, because of communicable diseases, pose a significant risk to the health or safety of others in the Early Head Start or Head Start program that cannot be eliminated or reduced by reasonable accommodation. This requirement must be implemented consistent with the requirements of the Americans with Disabilities Act and section 504 of the Rehabilitation Act. (2) Regular volunteers must be screened for tuberculosis in accordance with State, Tribal or local laws. In the absence of State, Tribal or local law, the Health Services Advisory Committee must be consulted regarding the need for such screenings (see 45 CFR 1304.3(20) for a definition of volunteer). (3) Grantee and delegate agencies must make mental health and wellness information available to staff with concerns that may affect their job performance.
1304.52(l) Training and development (p. 142)	(1) Grantee and delegate agencies must provide an orientation to all new staff, consultants, and volunteers that includes, at a minimum, the goals and underlying philosophy of Early Head Start and/or Head Start and the ways in which they are implemented by the program. (2) Grantee and delegate agencies must establish and implement a structured approach to staff training and development, attaching academic credit whenever possible. This system should be designed to help build relationships among staff and to assist staff in acquiring or increasing the knowledge and skills needed to fulfill their job responsibilities, in accordance with the requirements of 45 CFR 1306.23. (3) At a minimum, this system must include ongoing opportunities for staff to acquire the knowledge and skills necessary to implement the content of the Head Start Program Performance Standards. This program must also include: (i) Methods for identifying and reporting child abuse and neglect that comply with applicable State and local laws using, so far as possible, a helpful rather than a punitive attitude toward abusing or neglecting parents and other caretakers; and (ii) Methods for planning for successful child and family transitions to and from the Early Head Start or Head Start program. (4) Grantee and delegate agencies must provide training or orientation to Early Head Start and Head Start governing body members. Agencies must also provide orientation and ongoing training to Early Head Start and Head Start Policy Council and Policy Committee members to enable them to carry out their program governance responsibilities effectively. (5) In addition, grantee and delegate agencies offering the family child care program option must make available to family child care providers training on: (i) Infant, toddler, and preschool age child development; (ii) Implementation of curriculum (see § 1304.3(a)(5) for the definition of curriculum); (iii) Skill development for working with children with disabilities;

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.52(l), continued	(iv) Effective communication with infants, toddlers, and preschoolers and with their families; (v) Safety, sanitation, hygiene, health practices and certification in, at minimum, infant and child cardiopulmonary resuscitation (CPR); (vi) Identifying and reporting suspected child abuse or neglect; (vii) United States Department of Agriculture's Child and Adult Care Food Program; and (viii) Other areas necessary to increase the knowledge and skills of the family child care providers.
	1304.53 Facilities, Materials, and Equipment
1304.53(a) Head Start physical environment and facilities (p. 143)	(1) Grantee and delegate agencies must provide a physical environment and facilities conducive to learning and reflective of the different stages of development of each child. (2) Grantee and delegate agencies must provide appropriate space for the conduct of all program activities (see 45 CFR 1308.4 for specific access requirements for children with disabilities). (3) The center space provided by grantee and delegate agencies must be organized into functional areas that can be recognized by the children and that allow for individual activities and social interactions. (4) The indoor and outdoor space in Early Head Start or Head Start centers in use by mobile infants and toddlers must be separated from general walkways and from areas in use by preschoolers. (5) Centers must have at least 35 square feet of usable indoor space per child available for the care and use of children (i.e., exclusive of bathrooms, halls, kitchen, staff rooms, and storage places) and at least 75 square feet of usable outdoor play space per child. (6) Facilities owned or operated by Early Head Start and Head Start grantee or delegate agencies must meet the licensing requirements of 45 CFR 1306.30. (7) Grantee and delegate agencies must provide for the maintenance, repair, safety, and security of all Early Head Start and Head Start facilities, materials and equipment. (8) Grantee and delegate agencies must provide a center-based environment free of toxins, such as cigarette smoke, lead, pesticides, herbicides, and other air pollutants as well as soil and water contaminants. Agencies must ensure that no child is present during the spraying of pesticides or herbicides. Children must not return to the affected area until it is safe to do so. (9) Outdoor play areas at center-based programs must be arranged so as to prevent any child from leaving the premises and getting into unsafe and unsupervised areas. Enroute to play areas, children must not be exposed to vehicular traffic without supervision. (10) Grantee and delegate agencies must conduct a safety inspection, at least annually, to ensure that each facility's space, light, ventilation, heat, and other physical arrangements are consistent with the health, safety and developmental needs of children. At a minimum, agencies must ensure that: (i) In climates where such systems are necessary, there is a safe and effective heating and cooling system that is insulated to protect children and staff from potential burns; (ii) No highly flammable furnishings, decorations, or materials that emit highly toxic fumes when burned are used; (iii) Flammable and other dangerous materials and potential poisons are stored in locked cabinets or storage facilities separate from stored medications and food and are accessible only to authorized persons. All medications, including those required for staff and volunteers, are labeled, stored under lock and key, refrigerated if necessary, and kept out of the reach of children;

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1304.53(a), continued	(iv) Rooms are well lit and provide emergency lighting in the case of power failure; (v) Approved, working fire extinguishers are readily available; (vi) An appropriate number of smoke detectors are installed and tested regularly; (vii) Exits are clearly visible and evacuation routes are clearly marked and posted so that the path to safety outside is unmistakable (see 45 CFR 1304.22 for additional emergency procedures); (viii) Indoor and outdoor premises are cleaned daily and kept free of undesirable and hazardous materials and conditions; (ix) Paint coatings on both interior and exterior premises used for the care of children do not contain hazardous quantities of lead; (x) The selection, layout, and maintenance of playground equipment and surfaces minimize the possibility of injury to children; (xi) Electrical outlets accessible to children prevent shock through the use of child-resistant covers, the installation of child-protection outlets, or the use of safety plugs; (xii) Windows and glass doors are constructed, adapted, or adjusted to prevent injury to children; (xiii) Only sources of water approved by the local or State health authority are used; (xiv) Toilets and handwashing facilities are adequate, clean, in good repair, and easily reached by children. Toileting and diapering areas must be separated from areas used for cooking, eating, or children's activities; (xv) Toilet training equipment is provided for children being toilet trained; (xvi) All sewage and liquid waste is disposed of through a locally approved sewer system, and garbage and trash are stored in a safe and sanitary manner; and (xvii) Adequate provisions are made for children with disabilities to ensure their safety, comfort, and participation.
1304.53(b) Head Start equipment, toys, materials, and furniture (p. 144)	(1) Grantee and delegate agencies must provide and arrange sufficient equipment, toys, materials, and furniture to meet the needs and facilitate the participation of children and adults. Equipment, toys, materials, and furniture owned or operated by the grantee or delegate agency must be: (i) Supportive of the specific educational objectives of the local program; (ii) Supportive of the cultural and ethnic backgrounds of the children; (iii) Age-appropriate, safe, and supportive of the abilities and developmental level of each child served, with adaptations, if necessary, for children with disabilities; (iv) Accessible, attractive, and inviting to children; (v) Designed to provide a variety of learning experiences and to encourage each child to experiment and explore; (vi) Safe, durable, and kept in good condition; and (vii) Stored in a safe and orderly fashion when not in use. (2) Infant and toddler toys must be made of non-toxic materials and must be sanitized regularly. (3) To reduce the risk of Sudden Infant Death Syndrome (SIDS), all sleeping arrangements for infants must use firm mattresses and avoid soft bedding materials such as comforters, pillows, fluffy blankets or stuffed toys.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
	1305.3 Determining Community Strengths and Needs
1305.3(c) (p. 148)	Each Early Head Start and Head Start grantee must conduct a Community Assessment within its service area once every three years. The Community Assessment must include the collection and analysis of the following information about the grantee's Early Head Start or Head Start area: (1) The demographic make-up of Head Start eligible children and families, including their estimated number, geographic location, and racial and ethnic composition; (2) Other child development and child care programs that are serving Head Start eligible children, including publicly funded State and local preschool programs, and the approximate number of Head Start eligible children served by each; (3) The estimated number of children with disabilities four years old or younger, including types of disabilities and relevant services and resources provided to these children by community agencies; (4) Data regarding the education, health, nutrition and social service needs of Head Start eligible children and their families; (5) The education, health, nutrition and social service needs of Head Start eligible children and their families as defined by families of Head Start eligible children and by institutions in the community that serve young children; (6) Resources in the community that could be used to address the needs of Head Start eligible children and their families, including assessments of their availability and accessibility.
	1305.6 Selection Process
1305.6(a–d) (p. 150)	(a) Each Head Start program must have a formal process for establishing selection criteria and for selecting children and families that considers all eligible applicants for Head Start services. The selection criteria must be based on those contained in paragraphs (b) and (c) of this section. (b) In selecting the children and families to be served, the Head Start program must consider the income of eligible families, the age of the child, the availability of kindergarten or first grade to the child, and the extent to which a child or family meets the criteria that each program is required to establish in § 1305.3(c)(6). Migrant programs must also give priority to children from families whose pursuit of agricultural work required them to relocate most frequently within the previous two-year period. (c) At least 10 percent of the total number of enrollment opportunities in each grantee and each delegate agency during an enrollment year must be made available to children with disabilities who meet the definition for children with disabilities in § 1305.2(a). An exception to this requirement will be granted only if the responsible HHS official determines, based on such supporting evidence he or she may require, that the grantee made a reasonable effort to comply with this requirement but was unable to do so because there was an insufficient number of children with disabilities in the recruitment area who wished to attend the program and for whom the program was an appropriate placement based on their Individual Education Plans (IEP) or Individualized Family Service Plans (IFSP), with services provided directly by Head Start or Early Head Start in conjunction with other providers. (d) Each Head Start program must develop at the beginning of each enrollment year and maintain during the year a waiting list that ranks children according to the program's selection criteria to assure that eligible children enter the program as vacancies occur.
	1305.8 Attendance
1305.8(a–c) (p. 151)	(a) When the monthly average daily attendance rate in a center-based program falls below 85 percent, a Head Start program must analyze the causes of absenteeism. The analysis must include a study of the pattern of absences for each child, including the reasons for absences as well as the number of absences that occur on consecutive days.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1305.8(a–c), continued	(b) If the absences are a result of illness or if they are well documented absences for other reasons, no special action is required. If, however, the absences result from other factors, including temporary family problems that affect a child's regular attendance, the program must initiate appropriate family support procedures for all children with four or more consecutive unexcused absences. These procedures must include home visits or other direct contact with the child's parents. Contacts with the family must emphasize the benefits of regular attendance, while at the same time remaining sensitive to any special family circumstances influencing attendance patterns. All contacts with the child's family as well as special family support service activities provided by program staff must be documented. (c) In circumstances where chronic absenteeism persists and it does not seem feasible to include the child in either the same or a different program option, the child's slot must be considered an enrollment vacancy.
1306.20 Program Staffing Patterns	
1306.20(g) (p. 153)	Grantee and delegate agencies offering the family child care program option must ensure that in each family child care home where Head Start children are enrolled, the group size does not exceed the limits specified in this paragraph. Whenever present, not at school or with another care provider, the family child care provider's own children under the age of six years must be included in the count. (1) When there is one family child care provider, the maximum group size is six children and no more than two of the six may be under two years of age. When there is a provider and an assistant, the maximum group size is twelve children with no more than four of the twelve children under two years of age. (2) One family child care provider may care for up to four infants and toddlers, with no more than two of the four children under the age of 18 months. (3) Additional assistance or smaller group size may be necessary when serving children with special needs who require additional care.
1306.30 Provisions of Comprehensive Child Development Services	
1306.30(a–d) (p. 154)	(a) All Head Start grantees must provide comprehensive child development services, as defined in the Head Start Performance Standards. (b) All Head Start grantees must provide classroom or group socialization activities for the child as well as home visits to the parents. The major purpose of the classroom or socialization activities is to help meet the child's development needs and to foster the child's social competence. The major purpose of the home visits is to enhance the parental role in the growth and development of the child. (c) The facilities used by Early Head Start and Head Start grantee and delegate agencies for regularly scheduled center-based and combination program option classroom activities or home-based group socialization activities must comply with State and local requirements concerning licensing. In cases where these licensing standards are less comprehensive or less stringent than the Head Start regulations, or where no State or local licensing standards are applicable, grantee and delegate agencies are required to assure that their facilities are in compliance with the Head Start Program Performance Standards related to health and safety as found in 45 CFR 1304.53(a), Physical environment and facilities. (d) All grantees must identify, secure and use community resources in the provision of services to Head Start children and their families prior to using Head Start funds for these services.
1306.31(c) (p. 155)	When assigning children to a particular program option, Head Start grantees that operate more than one program option must consider such factors as the child's age, developmental level, disabilities, health or learning problems, previous preschool experiences and family situation. Grantees must also consider parents' concerns and wishes prior to making final assignments.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
	1306.32 Center-Based Program Option
1306.32(a) Class size (p. 155)	(1) Head Start classes must be staffed by a teacher and an aide or two teachers and, whenever possible, a volunteer. (2) Grantees must determine their class size based on the predominant age of the children who will participate in the class and whether or not a center-based double session variation is being implemented. (3) For classes serving predominantly four or five-year-old children, the average class size of that group of classes must be between 17 and 20 children, with no more than 20 children enrolled in any one class. (4) When double session classes serve predominantly four or five-year-old children, the average class size of that group of classes must be between 15 and 17 children. A double session class for four or five-year old children may have no more than 17 children enrolled. (See paragraph (c) of this section for other requirements regarding the double session variation.) (5) For classes serving predominantly three-year-old children, the average class size of that group of classes must be between 15 and 17 children, with no more than 17 children enrolled in any one class. (6) When double session classes serve predominantly three-year-old children, the average class size of that group of classes must be between 13 and 15 children. A double session class for three year- old children may have no more than 15 children enrolled. (See paragraph (c) of this section for other requirements regarding the double session variation.) (7) It is recommended that at least 13 children be enrolled in each center-based option class where feasible. (8) A class is considered to serve predominantly four- or five-year-old children if more than half of the children in the class will be four or five years old by whatever date is used by the State or local jurisdiction in which the Head Start program is located to determine eligibility for public school. (9) A class is considered to serve predominantly three-year-old children if more than half of the children in the class will be three years old by whatever date is used by the State or local jurisdiction in which Head Start is located to determine eligibility for public school. (10) Head Start grantees must determine the predominant age of children in the class at the start of the year. There is no need to change that determination during the year. (11) In some cases, State or local licensing requirements may be more stringent than these class requirements, preventing the required minimum numbers of children from being enrolled in the facility used by Head Start. Where this is the case, Head Start grantees must try to find alternative facilities that satisfy licensing requirements for the numbers of children cited above. If no alternative facilities are available, the responsible HHS official has the discretion to approve enrollment of fewer children than required above. (12) The chart below may be used for easy reference: [chart omitted, p. 156]
1306.32(b) Center-based program option requirements (p. 156)	(1) Classes must operate for four or five days per week or some combination of four and five days per week. (2) Classes must operate for a minimum of three and one-half to a maximum of six hours per day with four hours being optimal. (3) The annual number of required days of planned class operations (days when children are scheduled to attend) is determined by the number of days per week each program operates. Programs that operate for four days per week must provide at least 128 days per year of planned class operations. Programs that operate for five days per week must provide at least 160 days per year of planned class operations. Grantees implementing a combination of four and five days per week must plan to operate between 128 and 160 days per year. The minimum number of planned days of service per year can be determined by computing the relative number of four and five day weeks that the program is in operation. All center-based program options must provide a minimum of 32 weeks of scheduled days of class operations over an eight or nine month period. Every effort should be made to schedule makeup classes using existing resources if planned class days fall below the number required per year.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1306.32(b), continued	(4) Programs must make a reasonable estimate of the number of days during a year that classes may be closed due to problems such as inclement weather or illness, based on their experience in previous years. Grantees must make provisions in their budgets and program plans to operate makeup classes and provide these classes, when needed, to prevent the number of days of service available to the children from falling below 128 days per year. (5) Each individual child is not required to receive the minimum days of service, although this is to be encouraged in accordance with Head Start policies regarding attendance. The minimum number of days also does not apply to children with disabilities whose individualized education plan may require fewer planned days of service in the Head Start program. (6) Head Start grantees operating migrant programs are not subject to the requirement for a minimum number of planned days, but must make every effort to provide as many days of service as possible to each migrant child and family. (7) Staff must be employed for sufficient time to allow them to participate in pre-service training, to plan and set up the program at the start of the year, to close the program at the end of the year, to conduct home visits, to conduct health examinations, screening and immunization activities, to maintain records, and to keep service component plans and activities current and relevant. These activities should take place outside of the time scheduled for classes in center-based programs or home visits in home-based programs. (8) Head Start grantees must develop and implement a system that actively encourages parents to participate in two home visits annually for each child enrolled in a center-based program option. These visits must be initiated and carried out by the child's teacher. The child may not be dropped from the program if the parents will not participate in the visits. (9) Head Start grantees operating migrant programs are required to plan for a minimum of two parent-teacher conferences for each child during the time they serve that child. Should time and circumstance allow, migrant programs must make every effort to conduct home visits.
	1306.33 Home-Based Program Option
1306.33(c) (p. 158)	Group socialization activities must be focused on both the children and parents. They may not be conducted by the home visitor with babysitters or other temporary caregivers. (3) Grantees must follow the nutrition requirements specified in 45 CFR 1304.23(b)(2) and provide appropriate snacks and meals to the children during group socialization activities.
	1306.35 Family Child Care Program Option
1306.35(a) Grantee and delegate agency implementation (p. 159)	Grantee and delegate agencies offering the family child care program option must: (1) Hours of operation. Ensure that the family child care option, whether provided directly or via contractual arrangement, operates sufficient hours to meet the child care needs of families. (2) Serving children with disabilities. (i) Ensure the availability of family child care homes capable of serving children and families with disabilities affecting mobility as appropriate; and (ii) Ensure that children with disabilities enrolled in family child care are provided services which support their participation in the early intervention, special education, and related services required by their individual family service plan (IFSP) or individual education plan (IEP) and that the child's teacher has appropriate knowledge, training, and support. (3) Program Space-indoor and outdoor. Ensure that each family child care home has sufficient indoor and outdoor space which is usable and available to children. This space must be adequate to allow children to be supervised and safely participate in developmentally appropriate activities and routines that foster their cognitive, socio-emotional, and physical development, including both gross and fine motor. Family child care settings must meet State family child care regulations. (4) Policy Council role. The Policy Council must approve or disapprove the addition of family child care as a Head Start or Early Head Start program option. When families are enrolled in the Head Start or Early Head Start family child care program option, they must have proportionate representation on the Policy Council or policy committee.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1306.35(b) Facilities (p. 159)	(1) Safety plan. Grantees and delegate agencies offering the family child care program option must ensure the health and safety of children enrolled. The family child care home must have a written description of its health, safety, and emergency policies and procedures, and a system for routine inspection to ensure ongoing safety. (2) Injury prevention. Grantee and delegate agencies must ensure that: (i) Children enrolled in the Head Start family child care program option are protected from potentially hazardous situations. Providers must ensure that children are safe from the potential hazards posed by appliances (stove, refrigerator, microwave, etc.). Premises must be free from pests and the use of chemicals or other potentially harmful materials for controlling pests must not occur while children are on premises. (ii) Grantee and delegate agencies must ensure that all sites attended by children enrolled in Head Start and Early Head Start are equipped with functioning and properly located smoke and carbon monoxide detectors. (iii) Radon detectors are installed in family child care homes where there is a basement and such detectors are recommended by local health officials; (iv) Children are supervised at all times. Providers must have systems for assuring the safety of any child not within view for any period (e.g., the provider needs to use the bathroom or an infant is napping in one room while toddlers play in another room); (v) Providers ensure the safety of children whenever any body of water, road, or other potential hazard is present and when children are being transported; (vi) Unsupervised access by children to all water hazards, such as pools or other bodies of water, are prevented by a fence; (vii) There are no firearms or other weapons kept in areas occupied or accessible to children; (viii) Alcohol and other drugs are not consumed while children are present or accessible to children at any time; and (ix) Providers secure health certificates for pets to document up to date immunizations and freedom from any disease or condition that poses a threat to children's health. Family child care providers must ensure that pets are appropriately managed to ensure child safety at all times.
1306.35(c) Emergency plans (p. 160)	Grantee and delegate agencies offering the family child care option must ensure that providers have made plans to notify parents in the event of any emergency or unplanned interruption of service. The provider and parent together must develop contingency plans for emergencies. Such plans may include, but are not limited to, the use of alternate providers or the availability of substitute providers. Parents must be informed that they may need to pick the child up and arrange care if the child becomes ill or if an emergency arises.
	1308.4 Purpose and Scope of Disabilities Service Plan
1308.4(a–o) (p. 168)	(a) A Head Start grantee, or delegate agency, if appropriate, must develop a disabilities service plan providing strategies for meeting the special needs of children with disabilities and their parents. The purposes of this plan are to assure: (1) That all components of Head Start are appropriately involved in the integration of children with disabilities and their parents; and (2) That resources are used efficiently. (b) The plan must be updated annually. (c) The plan must include provisions for children with disabilities to be included in the full range of activities and services normally provided to all Head Start children and provisions for any modifications necessary to meet the special needs of the children with disabilities. (d) The Head Start grantee and delegate agency must use the disabilities service plan as a working document which guides all aspects of the agency's effort to serve children with disabilities. This plan must take into account 45 CFR Ch. XIII (10–1–14 Edition) the needs of the children for small group activities, for modifications of large group activities and for any individual special help.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1308.4(a–o), continued	(e) The grantee or delegate agency must designate a coordinator of services for children with disabilities (disabilities coordinator) and arrange for preparation of the disabilities service plan and of the grantee application budget line items for services for children with disabilities. The grantee or delegate must ensure that all relevant coordinators, other staff and parents are consulted. (f) The disability service plan must contain: (1) Procedures for timely screening; (2) Procedures for making referrals to the LEA for evaluation to determine whether there is a need for special education and related services for a child, as early as the child's third birthday; (3) Assurances of accessibility of facilities; and (4) Plans to provide appropriate special furniture, equipment and materials if needed. (g) The plan, when appropriate, must address strategies for the transition of children into Head Start from infant/toddler programs (0–3 years), as well as the transition from Head Start into the next placement. The plan must include preparation of staff and parents for the entry of children with severe disabilities into the Head Start program. (h) The grantee or delegate agency must arrange or provide special education and related services necessary to foster the maximum development of each child's potential and to facilitate participation in the regular Head Start program unless the services are being provided by the LEA or other agency. The plan must specify the services to be provided directly by Head Start and those provided by other agencies. The grantee or delegate agency must arrange for, provide, or procure services which may include, but are not limited to special education and these related services: (1) Audiology services, including identification of children with hearing loss and referral for medical or other professional attention; provision of needed rehabilitative services such as speech and language therapy and auditory training to make best use of remaining hearing; speech conservation; lip reading; determination of need for hearing aids and fitting of appropriate aids; and programs for prevention of hearing loss; (2) Physical therapy to facilitate gross motor development in activities such as walking prevent or slow orthopedic problems and improve posture and conditioning; (3) Occupational therapy to improve, develop or restore fine motor functions in activities such as using a fork or knife; (4) Speech or language services including therapy and use of assistive devices necessary for a child to develop or improve receptive or expressive means of communication; (5) Psychological services such as evaluation of each child's functioning and interpreting the results to staff and parents; and counseling and guidance services for staff and parents regarding disabilities; (6) Transportation for children with disabilities to and from the program and to special clinics or other service providers when the services cannot be provided on-site. Transportation includes adapted buses equipped to accommodate wheelchairs or other such devices if required; and (7) Assistive technology services or devices necessary to enable a child to improve functions such as vision, mobility or communication to meet the objectives in the IEP. (i) The disabilities service plan must include options to meet the needs and take into consideration the strengths of each child based upon the IEP so that a continuum of services available from various agencies is considered. (j) The options may include: (1) Joint placement of children with other agencies; (2) Shared provision of services with other agencies;

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1308.4(a–o), continued	(3) Shared personnel to supervise special education services, when necessary to meet State requirements on qualifications; (4) Administrative accommodations such as having two children share one enrollment slot when each child's IEP calls for part-time service because of their individual needs; and (5) Any other strategies to be used to insure that special needs are met. These may include: (i) Increased staff; (ii) Use of volunteers; and (iii) Use of supervised students in such fields as child development, special education, child psychology, various therapies and family services to assist the staff. (k) The grantee must ensure that the disabilities service plan addresses grantee efforts to meet State standards for personnel serving children with disabilities by the 1994–95 program year. Special education and related services must be provided by or under the supervision of personnel meeting State qualifications by the 1994–95 program year. (l) The disabilities service plan must include commitment to specific efforts to develop interagency agreements with the LEAs and other agencies within the grantee's service area. If no agreement can be reached, the grantee must document its efforts and inform the Regional Office. The agreements must address: (1) Head Start participation in the public agency's Child Find plan under Part B of IDEA; (2) Joint training of staff and parents; (3) Procedures for referral for evaluations, IEP meetings and placement decisions; (4) Transition; (5) Resource sharing; (6) Head Start commitment to provide the number of children receiving services under IEPs to the LEA for the LEA Child Count report by December 1 annually; and (7) Any other items agreed to by both parties. Grantees must make efforts to update the agreements annually. (m) The disabilities coordinator must work with the director in planning and budgeting of grantee funds to assure that the special needs identified in the IEP are fully met; that children most in need of an integrated placement and of special assistance are served; and that the grantee maintains the level of fiscal support to children with disabilities consistent with the Congressional mandate to meet their special needs. (n) The grant application budget form and supplement submitted with applications for funding must reflect requests for adequate resources to implement the objectives and activities in the disability services plan and fulfill the requirements of these Performance Standards. (o) The budget request included with the application for funding must address the implementation of the disabilities service plan. Allowable expenditures include: (2) Evaluation of children. When warranted by screening or rescreening results, teacher observation or parent request, arrangements must be made for evaluation of the child's development and functioning. If, after referral for evaluation to the LEA, evaluations are not provided by the LEA, they are an allowable expenditure. (3) Services. Program funds may be used to pay for services which include special education, related services, and summer services deemed necessary on an individual basis and to prepare for serving children with disabilities in advance of the program year.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1308.4(a–o), continued	(4) Making services accessible. Allowable costs include elimination of architectural barriers which affect the participation of children with disabilities, in conformance with 45 CFR part 84, Nondiscrimination on the Basis of Handicap in Program and Activities Receiving or Benefiting from Federal Financial Assistance and with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101). The Americans with Disabilities Act requires that public accommodations including private schools and day care centers may not discriminate on the basis of disability. Physical barriers in existing facilities must be removed if removal is readily achievable (i.e., easily accomplishable and able to be carried out without much difficulty or expense). If not, alternative methods of providing the services must be offered, if those methods are readily achievable. Alterations must be accessible. When alterations to primary function areas are made, an accessible path of travel to the altered areas (and the bathrooms, telephones and drinking fountains serving that area) must be provided to the extent that the added accessibility costs are not disproportionate to the overall cost of the alterations. Program funds may be used for ramps, remodeling or modifications such as grab bars or railings. Grantees must meet new statutory and regulatory requirements that are enacted. (5) Transportation. Transportation is a related service to be provided to children with disabilities. When transportation to the program site and to special services can be accessed from other agencies, it should be used. When it is not available, program funds are to be used to provide it. Special buses or use of taxis are allowable expenses if there are no alternatives available and they are necessary to enable a child to be served. (6) Special Equipment and Materials. Purchase or lease of special equipment and materials for use in the program and home is an allowable program expense. Grantees must make available assistive devices necessary to make it possible for a child to move, communicate, improve functioning or address objectives which are listed in the child's IEP.
	1308.5 Recruitment and Enrollment of Children with Disabilities
1308.5(a–f) (p. 171)	(a) The grantee or delegate agency outreach and recruitment activities must incorporate specific actions to actively locate and recruit children with disabilities. (b) A grantee must insure that staff engaged in recruitment and enrollment of children are knowledgeable about the provisions of 45 CFR part 84, Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance, and of the Americans with Disabilities Act of 1990, (42 U.S.C. 12101). (c) A grantee must not deny placement on the basis of a disability or its severity to any child when: (1) The parents wish to enroll the child, (2) The child meets the Head Start age and income eligibility criteria, (3) Head Start is an appropriate placement according to the child's IEP, and (4) The program has space to enroll more children, even though the program has made ten percent of its enrollment opportunities available to children with disabilities. In that case children who have a disability and nondisabled children would compete for the available enrollment opportunities. (d) The grantee must access resources and plan for placement options, such as dual placement, use of resource staff and training so that a child with a disability for whom Head Start is an appropriate placement according to the IEP is not denied enrollment because of: (1) Staff attitudes and/or apprehensions; (2) Inaccessibility of facilities; (3) Need to access additional resources to serve a specific child; (4) Unfamiliarity with a disabling condition or special equipment, such as a prosthesis; and (5) Need for personalized special services such as feeding, suctioning, and assistance with toileting, including catheterization, diapering, and toilet training.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1308.5(a–f), continued	(e) The same policies governing Head Start program eligibility for other children, such as priority for those most in need of the services, apply to children with disabilities. Grantees also must take the following factors into account when planning enrollment procedures: (1) The number of children with disabilities in the Head Start service area including types of disabilities and their severity; (2) The services and resources provided by other agencies; and (3) State laws regarding immunization of preschool children. Grantees must observe applicable State laws which usually require that children entering State preschool programs complete immunizations prior to or within thirty days after entering to reduce the spread of communicable diseases. (f) The recruitment effort of a Head Start grantee must include recruiting children who have severe disabilities, including children who have been previously identified as having disabilities.
	1308.6 Assessment of Children
1308.6(a–e) (p. 171)	(a) The disabilities coordinator must be involved with other program staff throughout the full process of assessment of children, which has three steps: (1) All children enrolled in Head Start are screened as the first step in the assessment process; (2) Staff also carry out on-going developmental assessment for all enrolled children throughout the year to determine progress and to plan program activities; (3) Only those children who need further specialized assessment to determine whether they have a disability and may require special education and related services proceed to the next step, evaluation. The disabilities coordinator has primary responsibility for this third step, evaluation, only. (b) Screening, the first step in the assessment process, consists of standardized health screening and developmental screening which includes speech, hearing and vision. It is a brief process, which can be repeated, and is never used to determine that a child has a disability. It only indicates that a child may need further evaluation to determine whether the child has a disability. Rescreening must be provided as needed. (1) Grantees must provide for developmental, hearing and vision screenings of all Early Head Start and Head Start children within 45 days of the child's entry into the program. This does not preclude starting screening in the spring, before program services begin in the fall. (2) Grantees must make concerted efforts to reach and include the most in need and hardest to reach in the screening effort, providing assistance but urging parents to complete screening before the start of the program year. (3) Developmental screening is a brief check to identify children who need further evaluation to determine whether they may have disabilities. It provides information in three major developmental areas: visual/motor, language and cognition, and gross motor/body awareness for use along with observation data, parent reports and home visit information. When appropriate standardized developmental screening instruments exist, they must be used. The disabilities coordinator must coordinate with the health coordinator and staff who have the responsibility for implementing health screening and with the education staff who have the responsibility for implementing developmental screening. (c) Staff must inform parents of the types and purposes of the screening well in advance of the screening, the results of these screenings and the purposes and results of any subsequent evaluations.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1308.6(a–e), continued	(d) Developmental assessment, the second step, is the collection of information on each child's functioning in these areas: gross and fine motor skills, perceptual discrimination, cognition, attention skills, self-help, social and receptive skills and expressive language. The disabilities coordinator must coordinate with the education coordinator in the on-going assessment of each Head Start child's functioning in all developmental areas by including this developmental information in later diagnostic and program planning activities for children with disabilities. (e) The disabilities coordinator must arrange for further, formal, evaluation of a child who has been identified as possibly having a disability, the third step. (1) The disabilities coordinator must refer a child to the LEA for evaluation as soon as the need is evident, starting as early as the child's third birthday. (2) If the LEA does not evaluate the child, Head Start is responsible for arranging or providing for an evaluation, using its own resources and accessing others. In this case, the evaluation must meet the following requirements: (i) Testing and evaluation procedures must be selected and administered so as not to be racially or culturally discriminatory, administered in the child's native language or mode of communication, unless it clearly is not feasible to do so. (ii) Testing and evaluation procedures must be administered by trained (State certified or licensed) personnel. (iii) No single procedure may be the sole criterion for determining an appropriate educational program for a child. (iv) The evaluation must be made by a multidisciplinary team or group of persons including at least one teacher or specialist with knowledge in the area of suspected disability. (v) Evaluators must use only assessment materials which have been validated for the specific purpose for which they are used. (vi) Tests used with children with impaired sensory, manual or communication skills must be administered so that they reflect the children's aptitudes and achievement levels and not just the disabilities. (vii) Tests and materials must assess all areas related to the suspected disability. (viii) In the case of a child whose primary disability appears to be a speech or language impairment, the team must assure that enough tests are used to determine that the impairment is not a symptom of another disability and a speech or language pathologist should be involved in the evaluation. (3) Parental consent in writing must be obtained before a child can have an initial evaluation to determine whether the child has a disability. (4) Confidentiality must be maintained in accordance with grantee and State requirements. Parents must be given the opportunity to review their child's records in a timely manner and they must be notified and give permission if additional evaluations are proposed. Grantees must explain the purpose and results of the evaluation and make concerted efforts to help the parents understand them. (5) The multidisciplinary team provides the results of the evaluation, and its professional opinion that the child does or does not need special education and related services, to the disabilities coordinator. If it is their professional opinion that a child has a disability, the team is to state which of the eligibility criteria applies and provide recommendations for programming, along with their findings. Only children whom the evaluation team determines need special education and related services may be counted as children with disabilities.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
	1308.7 Eligibility Criteria: Health Impairment
1308.7(a–d) (p. 173)	(a) A child is classified as health impaired who has limited strength, vitality or alertness due to a chronic or acute health problem which adversely affects learning. (b) The health impairment classification may include, but is not limited to, cancer, some neurological disorders, rheumatic fever, severe asthma, uncontrolled seizure disorders, heart conditions, lead poisoning, diabetes, AIDS, blood disorders, including hemophilia, sickle cell anemia, cystic fibrosis, heart disease and attention deficit disorder. (c) This category includes medically fragile children such as ventilator dependent children who are in need of special education and related services. (d) A child may be classified as having an attention deficit disorder under this category who has chronic and pervasive developmentally inappropriate inattention, hyperactivity, or impulsivity. To be considered a disorder, this behavior must affect the child's functioning severely. To avoid overuse of this category, grantees are cautioned to assure that only the enrolled children who most severely manifest this behavior must be classified in this category. (1) The condition must severely affect the performance of a child who is trying to carry out a developmentally appropriate activity that requires orienting, focusing, or maintaining attention during classroom instructions and activities, planning and completing activities, following simple directions, organizing materials for play or other activities, or participating in group activities. It also may be manifested in over activity or impulsive acts which appear to be or are interpreted as physical aggression. The disorder must manifest itself in at least two different settings, one of which must be the Head Start program site. (2) Children must not be classified as having attention deficit disorders based on: (i) Temporary problems in attention due to events such as a divorce, death of a family member or post-traumatic stress reactions to events such as sexual abuse or violence in the neighborhood; (ii) Problems in attention which occur suddenly and acutely with psychiatric disorders such as depression, anxiety and schizophrenia; (iii) Behaviors which may be caused by frustration stemming from inappropriate programming beyond the child's ability level or by developmentally inappropriate demands for long periods of inactive, passive activity; (iv) Intentional noncompliance or opposition to reasonable requests that are typical of good preschool programs; or (v) Inattention due to cultural or language differences. (3) An attention deficit disorder must have had its onset in early childhood and have persisted through the course of child development when children normally mature and become able to operate in a socialized preschool environment. Because many children younger than four have difficulty orienting, maintaining and focusing attention and are highly active, when Head Start is responsible for the evaluation, attention deficit disorder applies to four and five year old children in Head Start but not to three year olds. (4) Assessment procedures must include teacher reports which document the frequency and nature of indications of possible attention deficit disorders and describe the specific situations and events occurring just before the problems manifested themselves. Reports must indicate how the child's functioning was impaired and must be confirmed by independent information from a second observer.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
	1308.8 Eligibility Criteria: Emotional/Behavioral Disorders
1308.8(a–c) (p. 174)	(a) An emotional/behavioral disorder is a condition in which a child's behavioral or emotional responses are so different from those of the generally accepted, age-appropriate norms of children with the same ethnic or cultural background as to result in significant impairment in social relationships, self-care, educational progress or classroom behavior. A child is classified as having an emotional/behavioral disorder who exhibits one or more of the following characteristics with such frequency, intensity, or duration as to require intervention: (1) Seriously delayed social development including an inability to build or maintain satisfactory (age appropriate) interpersonal relationships with peers or adults (e.g., avoids playing with peers); (2) Inappropriate behavior (e.g., dangerously aggressive towards others, self-destructive, severely withdrawn, non-communicative); (3) A general pervasive mood of unhappiness or depression, or evidence of excessive anxiety or fears (e.g., frequent crying episodes, constant need for reassurance); or (4) Has a professional diagnosis of serious emotional disturbance. (b) The eligibility decision must be based on multiple sources of data, including assessment of the child's behavior or emotional functioning in multiple settings. (c) The evaluation process must include a review of the child's regular Head Start physical examination to eliminate the possibility of misdiagnosis due to an underlying physical condition.
	1308.9 Eligibility Criteria: Speech or Language Impairments
1308.9(a–e) (p. 174)	(a) A speech or language impairment means a communication disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment, which adversely affects a child's learning. (b) A child is classified as having a speech or language impairment whose speech is unintelligible much of the time, or who has been professionally diagnosed as having speech impairments which require intervention or who is professionally diagnosed as having a delay in development in his or her primary language which requires intervention. (c) A language disorder may be receptive or expressive. A language disorder may be characterized by difficulty in understanding and producing language, including word meanings (semantics), the components of words (morphology), the components of sentences (syntax), or the conventions of conversation (pragmatics). (d) A speech disorder occurs in the production of speech sounds (articulation), the loudness, pitch or quality of voice (voicing), or the rhythm of speech (fluency). (e) A child should not be classified as having a speech or language impairment whose speech or language differences may be attributed to: (1) Cultural, ethnic, bilingual, or dialectical differences or being non-English speaking; or (2) Disorders of a temporary nature due to conditions such as a dental problem; or (3) Delays in developing the ability to articulate only the most difficult consonants or blends of sounds within the broad general range for the child's age.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
	1308.10 Eligibility Criteria: Mental Retardation
1308.10(a–d) (p. 175)	(a) A child is classified as mentally retarded who exhibits significantly sub-average intellectual functioning and exhibits deficits in adaptive behavior which adversely affect learning. Adaptive behavior refers to age-appropriate coping with the demands of the environment through independent skills in self-care, communication and play. (b) Measurement of adaptive behavior must reflect objective documentation through the use of an established scale and appropriate behavioral/anecdotal records. An assessment of the child's functioning must also be made in settings outside the classroom. (c) Valid and reliable instruments appropriate to the age range must be used. If they do not exist for the language and cultural group to which the child belongs, observation and professional judgment are to be used instead. (d) Determination that a child is mentally retarded is never to be made on the basis of any one test alone.
	1308.11 Eligibility Criteria: Hearing Impairment Including Deafness
1308.11(a–c) (p. 175)	(a) A child is classified as deaf if a hearing impairment exists which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, and learning is affected. A child is classified as hard of hearing who has a permanent or fluctuating hearing impairment which adversely affects learning; or (b) Meets the legal criteria for being hard of hearing established by the State of residence; or (c) Experiences recurrent temporary or fluctuating hearing loss caused by otitis media, allergies, or eardrum perforations and other outer or middle ear anomalies over a period of three months or more. Problems associated with temporary or fluctuating hearing loss can include impaired listening skills, delayed language development, and articulation problems. Children meeting these criteria must be referred for medical care, have their hearing checked frequently, and receive speech, language or hearing services as indicated by the IEPs. As soon as special services are no longer needed, these children must no longer be classified as having a disability.
	1308.12 Eligibility Criteria: Orthopedic Impairment
1308.12(a–b) (p. 175)	(a) A child is classified as having an orthopedic impairment if the condition is severe enough to adversely affect a child's learning. An orthopedic impairment involves muscles, bones, or joints and is characterized by impaired ability to maneuver in educational or noneducational settings, to perform fine or gross motor activities, or to perform self-help skills and by adversely affected educational performance. (b) An orthopedic impairment includes, but is not limited to, spina bifida, cerebral palsy, loss of or deformed limbs, contractures caused by burns, arthritis, or muscular dystrophy.
	1308.13 Eligibility Criteria: Visual Impairment Including Blindness
1308.13(a–b) (p. 175)	(a) A child is classified as visually impaired when visual impairment, with correction, adversely affects a child's learning. The term includes both blind and partially seeing children. A child is visually impaired if: (1) The vision loss meets the definition of legal blindness in the State of residence; or (2) Central acuity does not exceed 20/200 in the better eye with corrective lenses, or visual acuity is greater than 20/200, but is accompanied by a limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees. (b) A child is classified as having a visual impairment if central acuity with corrective lenses is between 20/70 and 20/200 in either eye, or if visual acuity is undetermined, but there is demonstrated loss of visual function that adversely affects the learning process, including faulty muscular action, limited field of vision, cataracts, etc.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
	1308.14 Eligibility Criteria: Learning Disabilities
1308.14(a–c) (p. 176)	(a) A child is classified as having a learning disability who has a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in imperfect ability to listen, think, speak or, for preschool age children, acquire the precursor skills for reading, writing, spelling or doing mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, and aphasia. (b) An evaluation team may recommend that a child be classified as having a learning disability if: (1) The child does not achieve commensurate with his or her age and ability levels in one or more of the areas listed in (a) above when provided with appropriate learning experiences for the age and ability; or (2) The child has a severe discrepancy between achievement of developmental milestones and intellectual ability in one or more of these areas: oral expression, listening comprehension, pre-reading, pre-writing and pre-mathematics; or (3) The child shows deficits in such abilities as memory, perceptual and perceptual-motor skills, thinking, language and non-verbal activities which are not due to visual, motor, hearing or emotional disabilities, mental retardation, cultural or language factors, or lack of experiences which would help develop these skills. (c) This definition for learning disabilities applies to four and five year old children in Head Start. It may be used at a program's discretion for children younger than four or when a three year old child is referred with a professional diagnosis of learning disability. But because of the difficulty of diagnosing learning disabilities for three year olds, when Head Start is responsible for the evaluation it is not a requirement to use this category for three year olds.
	1308.15 Eligibility Criteria: Autism
1308.15 (p. 176)	A child is classified as having autism when the child has a developmental disability that significantly affects verbal and non-verbal communication and social interaction, that is generally evident before age three and that adversely affects educational performance.
	1308.16 Eligibility Criteria: Traumatic Brain Injury
1308.16 (p. 176)	A child is classified as having traumatic brain injury whose brain injuries are caused by an external physical force, or by an internal occurrence such as stroke or aneurysm, with resulting impairments that adversely affect educational performance. The term includes children with open or closed head injuries, but does not include children with brain injuries that are congenital or degenerative or caused by birth trauma.
1308.17 Eligibility Criteria: Other Impairments	
1308.17(a–e) (p. 176)	(a) The purposes of this classification, ''Other impairments,'' are: (1) To further coordination with LEAs and reduce problems of recordkeeping; (2) To assist parents in making the transition from Head Start to other placements; and (3) To assure that no child enrolled in Head Start is denied services which would be available to other preschool children who are considered to have disabilities in their State. (b) If the State Education Agency eligibility criteria for preschool children include an additional category which is appropriate for a Head Start child, children meeting the criteria for that category must receive services as children with disabilities in Head Start programs. Examples are ''preschool disabled,'' ''in need of special education,'' ''educationally handicapped,'' and ''non-categorically handicapped.'' (c) Children ages three to five, inclusive, who are experiencing developmental delays, as defined by their State and as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development, and who by reason thereof need special education and related services may receive services as children with disabilities in Head Start programs.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1308.17(a–e), continued	(d) Children who are classified as deaf-blind, whose concomitant hearing and visual impairments cause such severe communication and other developmental problems that they cannot be accommodated in special education programs solely for deaf or blind children are eligible for services under this category. (e) Children classified as having multiple disabilities whose concomitant impairments (such as mental retardation and blindness), in combination, cause such severe educational problems that they cannot be accommodated in special education programs solely for one of the impairments are eligible for services under this category. The term does not include deaf-blind children, for recordkeeping purposes.
1308.18 Disabilities/Health Service Coordination	
1308.18(a–d) (p. 177)	(a) The grantee must ensure that the disabilities coordinator and the health coordinator work closely together in the assessment process and follow up to assure that the special needs of each child with disabilities are met. (b) The grantee must ensure coordination between the disabilities coordinator and the staff person responsible for the mental health component to help teachers identify children who show signs of problems such as possible serious depression, withdrawal, anxiety or abuse. (c) Each Head Start director or designee must supervise the administration of all medications, including prescription and over-the-counter drugs, to children with disabilities in accordance with State requirements. (d) The health coordinator under the supervision of the Head Start director or designee must: (1) Obtain the doctor's instructions and parental consent before any medication is administered. (2) Maintain an individual record of all medications dispensed and review the record regularly with the child's parents. (3) Record changes in a child's behavior which have implications for drug dosage or type and share this information with the staff, parents and the physician. (4) Assure that all medications, including those required by staff and volunteers, are adequately labeled, stored under lock and key and out of reach of children, and refrigerated, if necessary.
1308.19 Developing Individualized Education Programs (IEPs)	
1308.19(a–k) (p. 177)	(a) When Head Start provides for the evaluation, the multidisciplinary evaluation team makes the determination whether the child meets the Head Start eligibility criteria. The multidisciplinary evaluation team must assure that the evaluation findings and recommendations, as well as information from developmental assessment, observations and parent reports, are considered in making the determination whether the child meets Head Start eligibility criteria. (b) Every child receiving services in Head Start who has been evaluated and found to have a disability and in need of special education must have an IEP before special education and related services are provided to ensure that comprehensive information is used to develop the child's program. (c) When the LEA develops the IEP, a representative from Head Start must attempt to participate in the IEP meeting and placement decision for any child meeting Head Start eligibility requirements. (d) If Head Start develops the IEP, the IEP must take into account the child's unique needs, strengths, developmental potential and the family strengths and circumstances as well as the child's disabilities. (e) The IEP must include: (1) A statement of the child's present level of functioning in the social-emotional, motor, communication, self help, and cognitive areas of development, and the identification of needs in those areas requiring specific programming. (2) A statement of annual goals, including short term objectives for meeting these goals.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1308.19(a–k), continued	(3) A statement of services to be provided by each Head Start component that are in addition to those services provided for all Head Start children, including transition services. (4) A statement of the specific special education services to be provided to the child and those related services necessary for the child to participate in a Head Start program. This includes services provided by Head Start and services provided by other agencies and non-Head Start professionals. (5) The identification of the personnel responsible for the planning and supervision of services and for the delivery of services. (6) The projected dates for initiation of services and the anticipated duration of services. (7) A statement of objective criteria and evaluation procedures for determining at least annually whether the short-term objectives are being achieved or need to be revised. (8) Family goals and objectives related to the child's disabilities when they are essential to the child's progress. (f) When Head Start develops the IEP, the team must include: (1) The Head Start disabilities coordinator or a representative who is qualified to provide or supervise the provision of special education services; (2) The child's teacher or home visitor; (3) One or both of the child's parents or guardians; and (4) At least one of the professional members of the multidisciplinary team which evaluated the child. (g) An LEA representative must be invited in writing if Head Start is initiating the request for a meeting. (h) The grantee may also invite other individuals at the request of the parents and other individuals at the discretion of the Head Start program, including those component staff particularly involved due to the nature of the child's disability. (i) A meeting must be held at a time convenient for the parents and staff to develop the IEP within 30 calendar days of a determination that the child needs special education and related services. Services must begin as soon as possible after the development of the IEP. (j) Grantees and their delegates must make vigorous efforts to involve parents in the IEP process. The grantee must: (1) Notify parents in writing and, if necessary, also verbally or by other appropriate means of the purpose, attendees, time and location of the IEP meeting far enough in advance so that there is opportunity for them to participate; (2) Make every effort to assure that the parents understand the purpose and proceedings and that they are encouraged to provide information about their child and their desires for the child's program; (3) Provide interpreters, if needed, and offer the parents a copy of the IEP in the parents' language of understanding after it has been signed; (4) Hold the meeting without the parents only if neither parent can attend, after repeated attempts to establish a date or facilitate their participation. In that case, document its efforts to secure the parents' participation, through records of phone calls, letters in the parents' native language or visits to parents' homes or places of work, along with any responses or results; and arrange an opportunity to meet with the parents to review the results of the meeting and secure their input and signature. (k) Grantees must initiate the implementation of the IEP as soon as possible after the IEP meeting by modifying the child's program in accordance with the IEP and arranging for the provision of related services. If a child enters Head Start with an IEP completed within two months prior to entry, services must begin within the first two weeks of program attendance.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
	1308.20 Nutrition Services
1308.20(a–d) (p. 179)	(a) The disabilities coordinator must work with staff to ensure that provisions to meet special needs are incorporated into the nutrition program. (b) Appropriate professionals, such as physical therapists, speech therapists, occupational therapists, nutritionists or dietitians must be consulted on ways to assist Head Start staff and parents of children with severe disabilities with problems of chewing, swallowing and feeding themselves. (c) The plan for services for children with disabilities must include activities to help children with disabilities participate in meal and snack times with classmates. (d) The plan for services for children with disabilities must address prevention of disabilities with a nutrition basis.
	1308.21 Parent Participation and Transition of Children into Head Start and from Head Start to Public School
1308.21(a–c) (p. 179)	(a) In addition to the many references to working with parents throughout these standards, the staff must carry out the following tasks: (1) Support parents of children with disabilities entering from infant/toddler programs. (2) Provide information to parents on how to foster the development of their child with disabilities. (3) Provide opportunities for parents to observe large group, small group and individual activities describe in their child's IEP. (4) Provide follow-up assistance and activities to reinforce program activities at home. (5) Refer parents to groups of parents of children with similar disabilities who can provide helpful peer support. (6) Inform parents of their rights under IDEA. (7) Inform parents of resources which may be available to them from the Supplemental Security Income (SSI) Program, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and other sources and assist them with initial efforts to access such resources. (8) Identify needs (caused by the disability) of siblings and other family members. (9) Provide information in order to prevent disabilities among younger siblings. (10) Build parent confidence, skill and knowledge in accessing resources and advocating to meet the special needs of their children. (b) Grantees must plan to assist parents in the transition of children from Head Start to public school or other placement, beginning early in the program year. (c) Head Start grantees, in cooperation with the child's parents, must notify the school of the child's planned enrollment prior to the date of enrollment.
1309.10 Applications for the Purchase, Construction and Major Renovation of Facilities	
1309.10(e) (p. 191)	(e) An assurance that the facility complies (or will comply when constructed or after completion of the renovations described in paragraph (b) of this section) with local licensing and code requirements, the access requirements of the Americans with Disabilities Act (ADA), if applicable, and section 504 of the Rehabilitation Act of 1973. The grantee will also assure that it has met the requirements of the Flood Disaster Protection Act of 1973, if applicable.
1309.33 Inspection	
1309.33 (p. 198)	A grantee which purchases a modular unit with grant funds or receives approval of a continuing purchase must have the modular unit inspected by a licensed engineer or architect within 15 calendar days of its installation or approval of a continuing purchase, and must submit to the responsible HHS official the engineer's or architect's inspection report within 30 calendar days of the inspection.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1310.11 Child Restraint Systems	
1310.11(a–b) (p. 203)	(a) Effective June 21, 2004, each agency providing transportation services must ensure that each vehicle used to transport children receiving such services is equipped for use of height- and weight-appropriate child safety restraint systems. (b) [Reserved]
1310.12 Required Use of School Buses or Allowable Alternate Vehicles	
1310.12(a–c) (p. 203)	(a) Effective December 30, 2006, each agency providing transportation services must ensure that children enrolled in its program are transported in school buses or allowable alternate vehicles that are equipped for use of height- and weight-appropriate child restraint systems, and that have reverse beepers. As provided in 45 CFR 1310.2(a), this paragraph does not apply to transportation services to children served under the home-based option for Head Start and Early Head Start. (b) Effective February 20, 2001, each Head Start and Early Head Start agency receiving permission from the responsible HHS official to purchase a vehicle with grant funds for use in providing transportation services to children in its program or a delegate agency's program must ensure that the funds are used to purchase a vehicle that is either a school bus or an allowable alternate vehicle and is equipped (1) For use of height- and weight-appropriate child restraint systems; and (2) With a reverse beeper. (c) As provided in 45 CFR 1310.2(a), paragraph (b) of this section does not apply to vehicles purchased for use in transporting children served under the home-based option for Head Start and Early Head Start.
1310.16 Driver Qualifications	
1310.16(a–c) (p. 204)	(a) Each agency providing transportation services must ensure that persons who drive vehicles used to provide such services, at a minimum: (1) In States where such licenses are granted, have a valid Commercial Driver's License (CDL) for vehicles in the same class as the vehicle the driver will operating; and (2) Meet any physical, mental, and other requirements established under applicable law or regulations as necessary to perform job-related functions with any necessary reasonable accommodations. (b) Each agency providing transportation services must ensure that there is an applicant review process for use in hiring drivers, that applicants for driver positions must be advised of the specific background checks required at the time application is made, and that there are criteria for the rejection of unacceptable applicants. The applicant review procedure must include, at minimum: (1) All elements specified in 45 CFR 1304.52(b), with additional disclosure by the applicant of all moving traffic violations, regardless of penalty; (2) A check of the applicant's driving record through the appropriate State agency, including a check of the applicant's record through the National Driver Register, if available in the State; and (3) After a conditional offer of employment to the applicant and before the applicant begins work as a driver, a medical examination, performed by a licensed doctor of medicine or osteopathy, establishing that the individual possesses the physical ability to perform any job-related functions with any necessary accommodations. (c) As provided in 45 CFR 1310.2(a), this section does not apply to transportation services to children served under the home-based option for Head Start and Early Head Start.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1310.17 Driver and Bus Monitor Training	
1310.17(a–f) (p. 205)	(a) Each agency providing transportation services must ensure that persons employed to drive vehicles used in providing such services will have received the training required under paragraphs (b) and (c) of this section no later than 90 days after the effective date of this section as established by §1310.2 of this part. The agency must ensure that drivers who are hired to drive vehicles used in providing transportation services after the close of the 90 day period must receive the training required under paragraphs (b) and (c) prior to transporting any child enrolled in the agency's program. The agency must further ensure that at least annually after receiving the training required under paragraphs (b) and (c), all drivers who drive vehicles used to provide such services receive the training required under paragraph (d) of this section. (b) Drivers must receive a combination of classroom instruction and behind-the-wheel instruction sufficient to enable each driver to: (1) operate the vehicle in a safe and efficient manner; (2) safely run a fixed route, including loading and unloading children, stopping at railroad crossings and performing other specialized driving maneuvers; (3) administer basic first aid in case of injury; (4) handle emergency situations, including vehicle evacuation procedures; (5) operate any special equipment, such as wheelchair lifts, assistance devices or special occupant restraints; (6) conduct routine maintenance and safety checks of the vehicle; and (7) maintain accurate records as necessary. (c) Drivers must also receive instruction on the topics listed in 45 CFR 1304.52(k)(1), (2) and (3)(i) and the provisions of the Head Start Program Performance Standards for Children with Disabilities (45 CFR 1308) relating to transportation services for children with disabilities. (d) Drivers must receive refresher training courses including the topics listed in paragraphs (b) and (c) of this section and any additional necessary training to meet the requirements applicable in the State where the agency operates. (e) Each agency providing transportation services must ensure that drivers who transport children receiving the services qualify under the applicable driver training requirements in its State. (f) Each agency providing transportation services must ensure that: (1) the annual evaluation of each driver of a vehicle used to provide such services includes an on-board observation of road performance; and (2) before bus monitors assigned to vehicles used to provide such services begin their duties, they are trained on child boarding and exiting procedure, use of child restraint systems, any required paperwork, responses to emergencies, emergency evacuation procedures, use of special equipment, child pick-up and release procedures and pre- and post-trip vehicle check.
1310.21 Safety Education	
1310.21(a–e) (p. 206)	(a) Each agency must provide training for parents and children in pedestrian safety. The training provided to children must be developmentally appropriate and an integral part of program experiences. The need for an adult to accompany a preschool child while crossing the street must be emphasized in the training provided to parents and children. The required transportation and pedestrian safety education of children and parents, except for the bus evacuation drills required by paragraph (d) of this section, must be provided within the first thirty days of the program year.

Table A.1. Health-Related Health Start Program Performance Standards, *Continued*

Standard Reference	Standard Text
1310.21(a–e), continued	(b) Each agency providing transportation services, directly or through another organization or an individual, must ensure that children who receive such services are taught: (1) safe riding practices; (2) safety procedures for boarding and leaving the vehicle; (3) safety procedures in crossing the street to and from the vehicle at stops; (4) recognition of the danger zones around the vehicle; and (5) emergency evacuation procedures, including participating in an emergency evacuation drill conducted on the vehicle the child will be riding. (c) Each agency providing transportation services must provide training for parents that: (1) emphasizes the importance of escorting their children to the vehicle stop and the importance of reinforcing the training provided to children regarding vehicle safety; and (2) complements the training provided to their children so that safety practices can be reinforced both in Head Start and at home by the parent. (d) Each agency providing transportation services must ensure that at least two bus evacuation drills in addition to the one required under paragraph (b)(5) of this section are conducted during the program year. (e) Each agency providing transportation services must develop activities to remind children of the safety procedures. These activities must be developmentally appropriate, individualized and be an integral part of the Head Start or Early Head Start program activities.
	1310.22 Children with Disabilities
1310.22(a–c) (p. 212)	(a) Effective December 30, 2006 each agency must ensure that there are school buses or allowable alternate vehicles adapted or designed for transportation of children with disabilities available as necessary to transport such children enrolled in the program. This requirement does not apply to the transportation of children receiving home-based services unless school buses or allowable alternate vehicles are used to transport the other children served under the home-based option by the grantee. Whenever possible, children with disabilities must be transported in the same vehicles used to transport other children enrolled in the Head Start or Early Head Start program. (b) Each Head Start, Early Head Start and delegate agency must ensure compliance with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.), the HHS regulations at 45 CFR part 84, implementing Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), and the Head Start Program Performance Standards on Services for Children with Disabilities (45 CFR part 1308) as they apply to transportation services. (c) Each agency must specify any special transportation requirements for a child with a disability when preparing the child's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP), and ensure that in all cases special transportation requirements in a child's IEP or IFSP are followed, including: (1) special pick-up and drop-off requirements; (2) special seating requirements; (3) special equipment needs; (4) any special assistance that may be required; and (5) any special training for bus drivers and monitors.

SOURCE: OHS, 2014.

Appendix B. Director and Health Manager Online Survey Methods

This appendix provides additional details regarding the methods used with the online Director Survey and the online Health Manager Survey, described in Chapter Two. In particular, we include additional information about the content of the surveys, the matching of survey data to the Head Start PIR, response totals and response rates for the surveys, the construction of analytic weights to account for survey nonresponse and the performance of the weights, and the estimated standard errors for survey percentages.

Survey Instruments

Paper versions of the online Director Survey and the online Health Manager Survey are included in Appendix C. A list of the Director Survey items by module is provided in Table B.1. Table B.2 provides the list of survey items in the Health Manager Survey, denoting those that are in the core survey and those in one of the four supplements.

Matching Survey Data to PIR Data

Data from the 2012 PIR (for the 2011–2012 Head Start program year) were used to identify the frame of HS/EHS grantee and delegate agencies for the Director Survey and Health Manager Survey, along with their key characteristics, including program type (Head Start or Early Head Start), program region, program size (based on funded enrollment), and the share of children who speak English (or, conversely, the share that is non–English-speaking). As indicated in Chapter Two, program type, region, size, and the language measure were used for stratifying programs for assignment to the Health Manager Survey supplements.

Upon completion of the survey, PIR data from the 2012–2013 program year were obtained, as those were aligned with the period covered by the data collection. Thus, where PIR data from 2012–2013 were available, all PIR measures derive from that year. If a measure was missing (e.g., program enrollment), we pulled the relevant variable from the 2011–2012 PIR, if it existed. The approach allowed us to identify measures for all but one program.

In the case of Region XII EHS programs, when grantees also have a Region XII HS program, they complete one combined PIR. As a result, the EHS program has missing information in the PIR, but the information recorded for the HS program is a combined result for Early Head Start and Head Start. In total, there were 13 such Region XII EHS programs paired with 13 Region XII HS programs where we treated the PIR data as missing for both because we did not have measures, such as enrollment, recorded separately for the two types of programs.

Table B.1. Questions in the Online Director Survey

Item Number	Question
	Module 1
DIR1	Who is responsible for the health services area of your EHS/HS program?
DIR3	Are you involved in any of the following activities related to the Health Services Advisory Committee (HSAC)?
DIR4	Which, if any, of the following special populations do you serve?
DIR5	What is the total operating budget (federal plus non-federal) for your EHS/HS program for the current grant year?
DIR6	What is the total budget (federal plus non-federal) for the health component in the current grant year?
DIR7	What happens if the need for treatment exceeds the designated budget?
DIR8	Provide your best estimate for the proportion of your health budget that goes towards covering out of pocket costs incurred by uninsured or underinsured families.
	Module 2
DED01	What is the highest grade or year of school that you completed?
DED02	Please describe how much coursework you had in the following areas.
DED03	Have you ever had any certificates, credentials, or state awarded licenses relating to health such as medicine, nursing, or oral health (include those earned outside of the United States)?
DED04	For each one that you have had, say whether it is active at this time.
DED05	Counting this program year, how many years have you ever worked . . .
DED06	Aside from your responsibilities as program director, do you have other responsibilities with this EHS/HS program?
DED07	Other than your responsibilities as director, what other responsibilities do you have with EHS/HS?
DED08	Before the position you have now, what other positions have you held at your program now or another EHS/HS program?
DDM01	What is your sex?
DDM02	Are you Hispanic, Latino/a, or Spanish origin?
DDM03	What is your race?
DDM04	How well do you speak English?
DDM05	Do you speak a language other than English at home?
DDM07	Is your age . . . ?
DDM08	Do you or did you ever have a child in your household who attends/attended EHS/HS?
DDM10	Is there anything else that you would like to share about the health services area or health needs of the children and families in your program?

Table B.2. Questions in the Online Health Manager Survey Core Instrument and Supplements A, B, C, or D

Item Number	Question	Supp.
	Module 1, Section 1	
STF01	As the Health Manager, how many EHS/HS sites (or centers) are you responsible for?	
STF02	How many hours per week do you usually work for EHS/HS?	
STF03	How many weeks per year do you work for EHS/HS?	
STF04	Aside from your responsibilities as Health Manager, do you have other responsibilities with this EHS/HS program?	
STF05	Other than your responsibilities as a health manager, what other responsibilities do you have with EHS/HS?	
STF06	What percentage of the hours that you work for EHS/HS is spent managing the health services area (this can include time planning health activities, supervising other health staff, maintaining budgets, etc.)?	
STF07	Below is a list of tasks that a health manager, other EHS/HS staff, or an outside consultant might do. Please select whether you or someone else is primarily responsible for each task.	A
STF07a	For those tasks that are done by someone else, please tell us who is primarily responsible for that task.	A
STF08	How often does your program have a regular meeting where the health services area or health-related program activities (e.g., screening days, health education of families) are discussed as either the only focus of or a dedicated part of the meeting agenda?	A
STF09	In your position now, what conditions or situations make it harder for you to do your job well?	
STF10	Do you or your health staff work with any of the following specialists (a specialist may be working as staff, a volunteer, or a consultant)?	A
STF11	Pick the sentence that best describes the languages spoken and understood by EHS/HS health staff.	
STF12	Do you have teachers, staff members, or consultants who provide guidance on ethnic customs, culture, traditions and values that may relate to the health, behavioral health, and oral health of the children and families in your program?	
	Module 1, Section 2	
PDV01	First think about training and other professional development activities you have had in the past **three years**. For each topic, please note whether the training was available and if you took it.	
PDV01a	For training you did take, please note whether the training was conducted in your local area (e.g., at your center or elsewhere in the community), outside of your local area, or online.	
PDV01b	For training you did take, please note who provided the training.	
PDV02	In the past three years, has your EHS/HS program provided training, either offsite or onsite, for other EHS/HS staff members (not including you) in . . .	A
PDV03	What kinds of things does your EHS/HS program do to make it easier for you or your staff to attend health-related trainings outside of the program? Does it . . .	
PDV04	In the past year, how many times did you connect with health managers in other EHS/HS programs to discuss challenges, share strategies and lessons learned, or to seek advice about your program?	

Table B.2. Questions in Online Health Manager Survey Core Instrument and Supplements A, B, C, or D, *Continued*

Item Number	Question	Supp.
	Module 1, Section 3	
HSC01	Do you run more than one HSAC?	
HSC02	How many individuals currently serve on the HSAC for your program?	
HSC03	Of these, how many would you consider to be "active" members? These are individuals who regularly engage in their role as a member of the HSAC.	
HSC04	Which of the following groups are represented as members on your HSAC?	
HSC05	Do you share an HSAC with another EHS/HS/MSHS/AIAN program?	
HSC06	With which type of Head Start program do you share the HSAC?	
HSC07	Do members of your HSAC have similar racial, ethnic, cultural, and language backgrounds to the children and families you serve?	A
HSC08	How often does your HSAC meet?	
HSC09	How often do you consult with one or more members of your HSAC apart from regular committee meetings	A
HSC10	How strongly do you agree or disagree with the following statements about your HSAC? The HSAC . . .	A
HSC11	Does your HSAC participate in annual self-assessment of your EHS/HS program's effectiveness?	A
	Module 1, Section 4	
POL01	According to your program's policy, about how many minutes per day should children take part in physical activity?	A
POL02	Think about how your program prepares children for school. Do you have health-specific goals or objectives that are part of your school readiness plan?	A
POL03	How do you keep track of the Consumer Product Safety Commission (CPSC) recalls or regulations (e.g., cribs, toys)?	A
POL04	How do you or your program ensure children are not left alone in the classroom, in another part of the facility?	A
POL05	How do you or your program ensure children are not left alone on the bus or van?	A
	Module 2, Section 1	
HLT01	What do you see as the health concerns facing the children and families served by your EHS/HS program?	
HLT02	About how much time per week do you and your staff spend managing these health issues and related complications?	B
HLT03	How many children in your program are not eligible for services under Part B or Part C of the Individuals with Disabilities Education Act, but have chronic health conditions that you feel need additional supports?	B
HLT04	What health condition(s) require enough additional supports in the EHS/HS program to make you think a diagnosis of that condition could make a child eligible for Part B or Part C services?	B
HLT05	What is the most common method you use to share information about the health of specific children among program staff?	B
	Module 2, Section 2	
PEN01	How often do you or your health team you communicate with parents or guardians about their child's health and developmental status, on average?	
PEN02	What is the most common method you use to share information with parents or guardians about the health of their child?	
PEN03	About how often do you meet with parents or guardians (either by phone or in person) to discuss the health management of a child with special health care needs (e.g., medication management, special supports) apart from daily interactions?	

Table B.2. Questions in Online Health Manager Survey Core Instrument and Supplements A, B, C, or D, *Continued*

Item Number	Question	Supp.
PEN04	When discussing the health of a child with their parent/guardian, what language is used?	B
PEN05	Does your program create Individual Family Partnership Agreements (IFPAs) with families specific to reaching health goals?	B
PEN06	Within your program, which of the following make it harder for you to communicate with parents or guardians about the health of their child?	B
	Module 3, Section 1	
SRF01	Does your program have a process for keeping track of health information about each child in your program?	
SRF02	Where do you get the information about the health of a child that you put in their health record?	
SRF03	How often do you update a child's health record?	
SRF04	Does your EHS/HS program regularly provide any of the following health screenings to children at no cost to them, in the program?	C
SRF05	What process or processes do you use to ensure that children receive necessary screenings?	C
SRF06	What funds are used to pay for screening?	C
SRF07	How often are the following efforts made to encourage parents or guardians to attend follow-up evaluations?	C
SRF08	What process(es) do you use to ensure that children receive follow-up evaluations?	C
	Module 3, Section 2	
MCR01	What types of medical care do health providers who come to the EHS/HS program provide on-site?	
MCR02	How are physical health services usually coordinated with other agencies or community partners?	C
MCR03	Do your partnership agreements with physical health care providers include the following?	C
MCR04	Thinking about the physical health of the children and families you serve, please describe your relationship with each of the following types of service providers during the past 12 months.	C
MCR05	What are the major barriers you face when working with parents or guardians to obtain screening and treatment services for physical health?	C
MCR06	Overall, how would you describe the ability of your partnerships to handle the physical health needs of children in your program?	
MCR07	How would you describe the ability of your partnerships to handle the needs of children living with disabilities in your program?	
MCR08	Thinking about the behavioral/mental health of the children and families you serve, please describe your relationship with each of the following types of service providers during the past 12 months.	C
MCR09	You mentioned that you use behavioral or mental health consultants. How do you use behavioral health consultants in your program?	C
MCR10	How are behavioral health services typically coordinated with other agencies or community partners?	C
MCR11	Do your partnership agreements with behavioral or mental health care providers include the following?	C
MCR12	What are the major barriers you face when working with parents/guardians to obtain necessary screening and treatment services for behavioral health?	C
MCR13	Overall, how would you describe the ability of your partnerships to handle the behavioral health needs of children in your program?	

Table B.2. Questions in Online Health Manager Survey Core Instrument and Supplements A, B, C, or D, *Continued*

Item Number	Question	Supp.
MCR14	Thinking about the oral health of the children and families you serve, please describe your relationship with each of the following types of service providers during the past 12 months.	D
MCR15	How are oral health services usually coordinated with other agencies or community partners?	D
MCR16	Do your partnership agreements with oral health care providers include the following?	D
MCR17	What are the major barriers you face when working with parents/guardians to obtain necessary screening and treatment services for oral health?	D
MCR18	Overall, how would you describe the ability of your partnerships to handle the oral health needs of children in your program?	
MCR19	What process or processes do you use to ensure that children receive follow-up services (for physical health, oral health, behavioral health)?	
MCR20	Is a set portion of your EHS/HS budget designated for treatment services for physical health, behavioral health and/or oral health?	
MCR21	What funds are used to pay for physical health, behavioral health and oral health treatment services?	
MCR22	Do you (or your staff) provide health services or health programs in the home?	
MCR23	What health service or health programs do you conduct in the home?	
MCR24	What barriers, if any, do you face when providing health services or programs in the home?	
	Module 4, Section 1	
PRG01	For the following list of health topics and health-promotion activities, please say whether you are addressing the topic with children and families in your EHS/HS program	D
PRG02	What factors/information contributed to you choosing these health topics as targets of health promotion?	D
PRG03	When there is a health topic that you feel needs to be addressed, how do you find possible resources or curriculum?	
PRG04	Please fill out the table below, listing the health topic or health promotion area being addressed, the name of the curricula, whether the curricula is “off the shelf,” adapted, or created by your program staff, and how long you have been using it.	D
PRG04a	You did not list I Am Moving, I Am Learning (IMIL) as a program that you are using. What are the reasons you are not currently using IMIL?	D
PRG05	To what extent are health materials selected or adapted to match the cultures and languages of families you serve?	D
PRG06	What method(s) do you use most often to share health promotion information with the families that you serve?	D
PRG07	What funds are used for prevention and health-promotion activities?	D
	Module 4, Section 2	
IMP01	What are the biggest challenges to starting health-promotion activities in your EHS/HS program?	
IMP02	Does your program do any of the following to encourage parents/guardians to take part in health-related activities or events? Do you:	D
IMP03	Does your program regularly monitor the health-promotion activities (e.g., education, curricula) offered to children?	D
IMP04	Does your program regularly monitor the health-promotion activities (e.g., education, curricula) offered to families?	D
IMP05	What types of information do you use to keep track of how your health-promotion activities are going?	D

Table B.2. Questions in Online Health Manager Survey Core Instrument and Supplements A, B, C, or D, *Continued*

Item Number	Question	Supp.
	Module 4, Section 3	
PRO01	Do you offer any of the following services to families?	
PRO02	Even if your program does not include EHS, does your program offer any services to pregnant women?	
PRO03	Which of the following services do you offer to pregnant women?	
PRO04	What funds are used to pay for family health-promotion activities?	D
	Module 5	
SWL01	Within the past year, has your program offered staff members the following . . . ?	B
SWL02	How often do staff members participate in emergency preparedness education sessions or trainings?	B
SWL03	What funds are used to pay for staff well-being activities?	B
	Module 6	
PRT01	With which agencies and organizations do you normally work to address or support the health needs of the children and families in your EHS/HS program?	A
PRT02	In your EHS/HS program, which of the following health needs are NOT being met (or being met well) by the agencies and organizations you work with?	
PRT03	What types of health-related services or knowledge do your community partners provide (e.g., help with referrals, treatment services, health education)?	A
PRT04	What types of health-related community partners do you NOT have a relationship with now, but you would LIKE TO have a relationship with?	
PRT05	In the past 12 months, how much did the following things make it difficult to provide health services or programs to your EHS/HS children and families?	A
PRT06	What percentage of your community partners are culturally responsive to the needs of your ethnic and linguistic minority families?	A
	Module 7	
EDUC01	What is the highest grade or year of school that you completed?	
EDUC02	Please describe how much coursework you had in the following areas.	
EDUC03	Have you ever had any licenses, certificates or credentials relating to health such as medicine, nursing, or oral health (include those earned outside of the United States)?	
EDUC04	For each one that you have had, say whether it is active at this time.	
EDUC05	Have you completed training to become a Child Care Health Consultant (CCHC)?	B
EDUC06	Counting this program year, how many years have you ever worked . . .	B
EDUC07	Before the position you have now, what other positions have you held at your program now or another EHS/HS program?	
DEM01	What is your sex?	
DEM02	Are you Hispanic, Latino/a, or Spanish origin?	
DEM03	What is your race?	
DEM04	How well do you speak English?	
DEM05	Do you speak a language other than English at home?	
DEM07	Is your age . . . ?	
DEM08	About how much do you make each year at EHS/HS?	
DEM09	Do you or did you ever have a child in your household who attends/attended EHS/HS?	

Table B.2. Questions in Online Health Manager Survey Core Instrument and Supplements A, B, C, or D, *Continued*

Item Number	Question	Supp.
DEM10	How satisfied are you with your current position as a health manager?	
DEM11	Is there anything else that you would like to mention about your experience with the health services area of your program?	
FUP01	We reached you at [email address]. Is this the best email address to reach you? If no, please enter your preferred email address.	
FUP02	Is there a phone number we can use to get in touch with you? If yes, please enter the phone number starting with the area code.	
FUP03	What is the best time of day for our study staff member to call you?	
FUP04	Is there anything else we should know about the best time or method to reach you?	

NOTES: Questions are included in the core survey instrument unless indicated in the last column, where items in the supplements are designated as A, B, C, or D.

Response Totals and Response Rates

Table 2.2 in Chapter Two indicated that 2,778 programs active in the 2012–2013 program year were eligible for the survey. Based on the PIR for 2011–2012, which was the latest PIR information available in November 2012, when the list of directors was identified, the eligible programs were headed by 1,965 unique directors. Those directors were invited to take the Director Survey. The 1,627 directors who completed the survey or partially completed the survey (at least far enough to give us a referral to their health managers) gave us referrals to 2,013 health managers, who were then invited to participate in the Health Manager Survey.

In Chapter Two, we reported that the response rates for the Director Survey and the Health Manager Survey were 83 percent and 73 percent, respectively. Table B.3 provides details supporting those reported response rates. For each type of respondent, we list the number invited to participate, the number of explicit refusals (i.e., those who did not consent to take the online survey), and the other cases of nonresponse (i.e., those who did not take the survey before the end of the field period). The number of responses, both partial survey responses and complete survey responses, are also tallied. These figures are used to calculate the American Association for Public Opinion Research (AAPOR, 2015) cooperation rate, the refusal rate, and the response rate shown in Table B.3. The cooperation rate and the response rate are each calculated two ways: (1) based only on cases with complete surveys and (2) based on completed cases and cases with a partial response.

Analyses of the survey data reported in Chapters Three to Fifteen are typically presented for all programs and separately for HS programs and EHS programs. For results based on the PIR, the Director Survey, and core questions in the Health Manager Survey, we also report results separately for Region XI AIAN programs and Region XII MSHS programs. Table B.4 shows the sample sizes that apply for the Director Survey and the Health Manager Survey, in total and by

program type. For the Health Manager Survey, the sample sizes associated with each supplemental module are also shown.

Table B.3. Director Survey and Health Manager Survey Response Rates

Measures	Survey Respondent	
	Directors	Health Managers
Invited to complete survey (*N*)	1,965	2,013
Did not consent to survey	6	23
Did not respond	332	525
Total nonresponse	338	548
Completed survey (partial)	191	124
Completed survey	1,436	1,341
Total response	1,627	1,465
Cooperation rate (%)		
Completes only	87.9	90.1
Completes and partials	99.6	98.5
Refusal rate (%)	0.3	1.1
Response rate (%)		
Completes only	73.1	66.6
Completes and partials	82.8	72.8

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director and Health Manager Surveys.
NOTES: Results are unweighted. Rates correspond to AAPOR (2015) rates as follows: cooperation rate 1 (completes only), cooperation rate 2 (includes partials), refusal rate 3, response rate 3 (completes only), and response rate 4 (includes partials).

Table B.4 also records the number of programs represented by the director respondents and by the health manager respondents. Because directors may represent more than one program (e.g., an HS program and an EHS program), the 1,627 directors represent a total of 2,330 programs. Likewise, some health managers represent more than one program, but in other cases, more than one health manager from a program responded to the survey. Thus, in aggregate, the 1,465 health managers represent 1,902 HS and EHS programs. When considering the 1,176 HS programs, the number of health manager respondents is 1,264 because some programs have more than one health manager respondent. Likewise, 795 health managers responded for the 726 EHS programs.

Table B.5 considers the survey response rates at the program level and how response rates vary with program characteristics recorded in the PIR. The first column shows the distribution of the 2,778 programs in the survey frame and how they are distributed based on following characteristics: program type (Head Start or Early Head Start); program region (Region I to Region XII); program size, based on funded enrollment slots (divided into three categories of roughly equal size); and share of children speaking English (also divided into three categories of approximately equal size). (The program enrollment and language shares are not available for 27 programs because of missing PIR data.)

Table B.4. Number of Director and Health Manager Respondents: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Director respondents					
Total	1,627	1,412	852	107	43
Programs represented by director respondents					
Total	2,330	1,462	868	145	55
Health manager respondents					
Total	1,465	1,264	795	76	46
By supplement					
Supplement A	373	331	205	20	13
Supplement B	376	323	204	23	16
Supplement C	359	305	186	14	9
Supplement D	357	305	200	19	8
Programs represented by health manager respondents					
Total	1,902	1,176	726	101	48
By supplement					
Supplement A	486	300	186	27	14
Supplement B	483	298	185	31	14
Supplement C	470	252	178	15	11
Supplement D	465	286	179	28	9

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director and Health Manager Survey.
NOTE: Results are unweighted.

Table B.5 also tabulates the distribution of the 2,330 programs with a Director Survey response and the 1,902 programs with a Health Manager Survey response in terms of these same characteristics (i.e., program type, region, size, and share of children speaking English). For each characteristic, the response rates to the Director Survey and the Health Manager Survey are calculated. For both surveys, the share of HS/EHS programs represented among the survey respondents is very similar. There are some differences by program region, with the highest response rates for Region I and Region X (more than 90 percent for the Director Survey and 80 to 85 percent for the Health Manager Survey). Because the Region XI AIAN cases were not fielded as long, the response rate is lowest for that region. The response rates to both surveys are also somewhat lower for small programs (those up to 150 slots), compared with programs in the middle- and high-enrollment categories. In terms of language composition of the children served, the response rates are consistently highest for the middle group, programs with 70 to 95 percent of children speaking English. Response rates are somewhat lower for those with a lower and higher share of English speakers.

Table B.5. Response Rates for Director and Health Manager Surveys: By Program Characteristics

Program Characteristics	All Programs, 2012–2013 PIR Frame (*N*)	Programs with Director Survey Response (*N*)	Director Survey Response Rate (%)	Programs with Health Manager Survey Response (*N*)	Health Manager Response Rate (%)
Total	2,778	2,330	83.9	1,902	68.5
Program type					
Head Start	1,767	1,462	82.7	1,176	66.6
Early Head Start	1,011	868	85.9	726	71.8
Program region					
Region I	138	128	92.8	110	79.7
Region II	325	257	79.1	200	61.5
Region III	245	213	86.9	181	73.9
Region IV	412	364	88.3	299	72.6
Region V	467	382	81.8	301	64.5
Region VI	282	233	82.6	190	67.4
Region VII	145	127	87.6	110	75.9
Region VIII	132	114	86.4	97	73.5
Region IX	259	211	81.5	173	66.8
Region X	108	101	93.5	92	85.2
Region XI (AIAN)	198	145	73.2	101	51.0
Region XII (MSHS)	67	55	82.1	48	71.6
Program size (funded enrollment)					
Small (1 to 150 slots)	957	755	78.9	592	61.9
Medium (151 to 349 slots)	893	785	87.9	643	72.0
Large (350 slots or more)	901	769	85.3	648	71.9
Missing	27	21	77.8	19	70.4
Share of children speaking English (%)					
Low (up to 70%)	903	725	80.3	572	63.3
Medium (70% up to 95%)	927	818	88.2	688	74.2
High (95% to 100%)	921	766	83.2	623	67.6
Missing	27	21	77.8	19	70.4

SOURCE: Authors' analysis of 2012–2013 PIR data and the Head Start Health Manager Descriptive Study's Director and Health Manager Surveys.
NOTES: The response rates in this table measure the percentage of programs in the PIR frame represented by the respondents to the Director Survey and the respondents to the Health Manager Survey. This differs from the AAPOR response rates reported in Table B.3.

Survey Weights

Despite extensive efforts, the participation of directors and health managers in the online surveys did not reach the target of 100 percent participation. Thus, it is appropriate to build analytic weights to account for the pattern of nonresponse, such as the variation reflected in Table B.5. We begin by describing the calculation of the weights and conclude with an assessment of the performance of the weights.

Calculation of the Weights

As described in Chapter Two, the online surveys began with the Director Survey, where the frame of HS/EHS directors was identified in the PIR. Directors who complete a survey referred

their health managers, who then became the frame for inviting health managers to take a second online survey, the Health Manager Survey. Analytically, we wished to analyze the data in three ways:

1. survey responses of directors with the HS/EHS program (grantee or delegate agency) as the unit of analysis
2. survey responses of health managers with the HS/EHS program as the unit of analysis
3. survey responses of health managers with the health manager as the unit of analysis.

This required the construction of three corresponding weights:

I. director weight, programs as the unit of analysis
II. health manager weight, programs as the unit of analysis
III. health manager weight, health managers as the unit of analysis.

A first set of these weights was constructed based on cases with complete survey responses only (variant A). A second set of weights (variant B) was based on cases with complete and partial survey responses. Thus, in total, we constructed six weights:

- weight I-A for the director weight using complete survey responses
- weight I-B for the director weight using complete and partial survey responses
- weight II-A for the health manager weight, programs as the unit of analysis, using complete survey responses
- weight II-B for the health manager weight, programs as the unit of analysis, using complete and partial survey responses
- weight III-A for the health manager weight, health managers as the unit of analysis, using complete survey responses
- weight III-B for the health manager weight, health managers as the unit of analysis, using complete and partial survey responses.

The director weight for complete survey responses (weight I-A) was constructed first based on a logistic regression that estimated the probability of a director completing a survey (or at least partially completing the survey for weight I-B), conditional on the following characteristics:

- program type (i.e., Head Start, Early Head Start, AIAN Early Head Start or Head Start, and MSHS Head Start or Early Head Start)
- Head Start region (i.e., Regions I to X)
- program size based on 2011–2012 enrollment (divided into three approximate equal sized tertiles, as in Table B.5)
- percentage of members of the program who speak English (divided into three equal-sized groups, as in Table B.5).

Note that the logistic model was formulated so that directors of multiple programs are represented in the data, once for each program they direct. Based on the logistic regression, the inverse of the likelihood of completing the interview was computed as the weight. One director weight is based on the complete survey responses (I-A), and a second weight is based on the records with either complete or partial responses (I-B). Note that to avoid weight outliers, we set

the weights to be truncated at three, where any weight larger than three would be reduced to three. After collapsing several covariates with small cells, such truncation was not needed any more, as all weights were smaller than three.

Next, for health manager responses to represent program-level information, we also constructed weights to account for nonresponse (weight II). Because a health manager can only respond to the survey if he or she is referred by a director, the weight associated with the health manager responses is a combination of the director weight and the likelihood of a health manager responding to each survey assigned to him or her. Conditional on the same covariates as in the case of the directors (see above), in addition to the total number of grants managed by a health manager, we computed the probability of a health manager answering the survey. This probability was then multiplied by the probability of a director answering the survey. The inverse of the obtained probability is the weight associated with health manager responses. Again, we created a version of the weight based on complete health manager respondents (II-A) and another based on completes and partials (II-B).

Some analyses are conducted at the health manager level (see Chapter Three), so we also estimated a health manager–level weight (weight III). Because a health manager can be referred by multiple directors (up to two in our data), we estimated the unconditional probability of a health manager responding as the product of the probability of responding (conditional of being referred) multiplied by the probability of being referred by a director. But one health manager could be referred by up to two directors, so the director probability to be used in this case is the probability of being referred by at least one director. For a health manager referred by two directors A and B, this is estimated as:

$$\begin{aligned} Prob(A \text{ or } B) &= Prob(A) + Prob(B) - Prob(A \text{ and } B) \\ &= Prob(A) + Prob(B) - Prob(A)Prob(B) \end{aligned} \quad \text{(B.1)}$$

The third term of equation B.1 in the initial expression, where *Prob(A and B)* is substituted by *Prob(A)* x *Prob(B)*, can be used because the event of director A referring a health manager should be independent of director B referring the same health manager. Also because a director can represent more than one program, the probabilities *P(A)* will be computed as the probability of answering at least one of the surveys assigned to a director. The health manager–level weight is estimated as the inverse of the unconditional probability of a health manager responding. One version of this weight is based on complete responses (III-A), while a second includes the incompletes (III-B).

Performance of the Weights

One way to assess the performance of the analytic weights is to take advantage of the fact that we have PIR data for all HS/EHS programs (subject to a few cases with missing PIR data, as shown in Table B.5). Thus, we can examine program characteristics based on the PIR data for the frame of all programs. Since all programs are represented (i.e., a census), we have "the truth," which can then be compared with the estimate we would get when we have the PIR data only for those directors who responded to the Director Survey or only the health managers who responded to the Health Manager Survey. If our analytic weights adjust for the survey nonresponse patterns, we should be able to generate weighted estimates based on our pool of director or health manager responses that match "the truth" when the characteristic is known for all programs.

Table B.6 shows that the distribution of programs with respondents in the Director Survey and the Health Manager Survey, when weighted, replicates the distribution of all HS/EHS programs in the PIR frame in terms of program type, region, size, and English language share. The weights therefore correct for the small variations in response rates across the program characteristics shown earlier, in Table B.5.

Table B.6. Characteristics for Programs in PIR Frame, Programs with Director Survey Responses, and Programs with Health Manager Survey Respondents

		Unweighted		Weighted	
Program Characteristics	**All Programs, 2012–2013 PIR Frame**	**Programs with Director Survey Response**	**Programs with Health Manager Survey Response**	**Programs with Director Survey Response**	**Programs with Health Manager Survey Response**
Program type (% distribution)					
Head Start	63.6	62.7	61.8	63.6	64.0
Early Head Start	36.4	37.3	38.2	36.4	36.0
Program region (% distribution)					
Region I	5.0	5.5	5.8	5.0	4.8
Region II	11.7	11.0	10.5	11.7	12.3
Region III	8.8	9.1	9.5	8.8	8.8
Region IV	14.8	15.6	15.7	14.9	14.5
Region V	16.8	16.4	15.8	16.8	16.8
Region VI	10.2	10.0	10.0	10.2	10.2
Region VII	5.2	5.5	5.8	5.2	5.2
Region VIII	4.8	4.9	5.1	4.7	4.5
Region IX	9.3	9.1	9.1	9.3	9.4
Region X	3.9	4.3	4.8	3.9	3.7
Region XI (AIAN)	7.1	6.2	5.3	7.1	7.4
Region XII (MSHS)	2.4	2.4	2.5	2.4	2.4
Program size					
Average enrollment (*N*)	400.2	406.0	416.7	401.1	398.9
Enrollment distribution (% distribution)					
Small (1 to 150 slots)	34.8	32.7	31.4	33.0	32.4
Medium (151 to 349 slots)	32.5	34.0	34.1	34.0	34.5
Large (350 slots or more)	32.8	33.3	34.4	33.1	33.0
[Missing]	*1.0*	*0.9*	*1.0*	*0.9*	*0.9*

Table B.6. Characteristics for Programs in PIR Frame, Programs with Director Survey Responses, and Programs with Health Manager Survey Respondents, *Continued*

Program Characteristics	All Programs, 2012–2013 PIR Frame	Unweighted: Programs with Director Survey Response	Unweighted: Programs with Health Manager Survey Response	Weighted: Programs with Director Survey Response	Weighted: Programs with Health Manager Survey Response
Share of children speaking English (%)					
Average share (%)	74.6	75.4	76.0	74.6	74.0
Share distribution (% distribution)					
Low (up to 70%)	32.8	31.4	30.4	32.6	33.0
Medium (70% up to 95%)	33.7	35.4	36.5	34.7	34.7
High (95% to 100%)	33.5	33.2	33.1	32.7	32.2
[Missing]	*1.0*	*0.9*	*1.0*	*0.9*	*0.9*
N	2,778	2,330	1,902	2,330	1,902

SOURCE: Authors' analysis of 2012–2013 PIR data and the Head Start Health Manager Descriptive Study's Director and Health Manager Surveys.
NOTES: Results are weighted to account for survey nonresponse in the last two columns using complete and partial survey responses and the B variants of the weights. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table B.7 shows the result of this exercise for a number of the PIR variables reported in the body of the report (see Chapter Six). In all cases, for all HS/EHS programs or HS programs and EHS programs separately, the indicator based on the survey respondents (weighted) matches the unweighted PIR result within a few tenths of a percentage point. The difference between "the truth" and our weighted estimate is a little larger for the Region XI and Region XII group of programs, but that is to be expected given the small set of programs in those two special regions, even when data are available for all programs in those regions.

Table B.7. Program Characteristics Based on Unweighted PIR Data and Weighted Survey Respondents: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Hours per week health manager spends coordinating services					
Unweighted PIR data	20.0	21.9	16.7	20.6	19.7
Weighted survey respondents					
Director survey respondents	20.1	22.0	16.7	19.4	21.1
Health manager survey respondents	20.3	22.2	16.8	19.3	21.5
Children with health insurance at enrollment (%)					
Unweighted PIR data	94.2	93.8	94.7	86.7	80.5
Weighted survey respondents					
Director Survey respondents	94.1	93.8	94.7	86.6	79.2
Health Manager Survey respondents	94.2	93.8	95.0	85.4	77.8
Among children with health insurance at enrollment, those with Medicaid and/or SCHIP (%)					
Unweighted PIR data	88.9	87.6	91.1	74.1	94.6

Table B.7. Program Characteristics Based on Unweighted PIR Data and Weighted Survey Respondents: By Program Type, *Continued*

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Weighted survey respondents					
Director Survey respondents	88.5	87.1	90.9	71.8	93.9
Health Manager Survey respondents	88.4	87.0	90.9	70.6	94.2
Children with an ongoing source of continuous, accessible health care at enrollment (%)					
Unweighted PIR data	93.9	93.9	94.0	92.4	92.1
Weighted survey respondents					
Director Survey respondents	94.0	94.0	94.0	92.2	92.6
Health Manager Survey respondents	94.1	93.9	94.4	91.5	92.1
Children receiving services through the IHS at enrollment (%)					
Unweighted PIR data	5.2	5.9	4.0	65.7	0.0
Weighted survey respondents					
Director Survey respondents	5.2	5.9	4.0	65.1	0.0
Health Manager Survey respondents	5.6	6.3	4.2	67.0	0.0
Children receiving services through a migrant community health center at enrollment (%)					
Unweighted PIR data	0.5	0.7	0.1	0.1	25.8
Weighted survey respondents					
Director Survey respondents	0.5	0.7	0.2	0.0	25.2
Health Manager Survey respondents	0.6	0.8	0.1	0.0	30.4

SOURCE: Authors' analysis of 2012–2013 PIR data and the Head Start Health Manager Descriptive Study's Director and Health Manager Surveys.

NOTES: Percentages are computed for nonmissing cases. PIR data are missing for six programs in total: four HS programs and two EHS programs (one of which is in Region XII). In addition, Region XII programs that have both HS and EHS complete a single, combined PIR, so we are not able to separately identify the measures in this table for the HS and EHS components of those programs. Thus, results are missing for 13 Region XII HS programs and 13 Region XII EHS programs. There are 2,324 programs with Director Survey respondents that match to valid PIR data (six missing cases), and 1,897 programs with Health Manager Survey respondents that match to valid PIR data (five missing cases).

Standard Errors for Survey Tabulations

All results reported for the Director Survey and the Health Manager Survey are measured with error because we do not have a 100 percent response rate. In the case of survey percentages, the standard error, *SE*, associated with any given percentage reported in the body of the report or in Appendix F, after dividing by 100 so that it is a proportion, can be approximated by:[33]

$$SE = \sqrt{\frac{p(1-p)}{N}}, \quad \text{(B.2)}$$

[33] We show the standard-error formulation for unweighted data for simplicity.

where p is the estimated proportion from the survey responses and N is the number of survey respondents. Given this formulation, the standard error will decrease as the number of survey respondents, N, increases. In addition, the standard error is smallest for values of p close to 0 (i.e., closest to 0 percent and 100 percent) and largest when p is 0.5 (i.e., 50 percent).

Standard Errors for Survey Tabulations in the Body of the Report

Rather than report standard errors in all tables in the body of the report, Table B.8 provides a lookup table that shows the approximate standard error for a given value of p (where all results in the body of the report are shown as percentages, or 100 multiplied by p). Panel A shows standard errors for analyses, such as those in Chapter Three, where the health manager is the unit of analysis and the question is in the survey core. Panel B shows the equivalent standard errors for questions in the survey supplement when the health manager is the unit of analysis. Results presented in all other chapters use the program as the unit of analysis. For these results, the standard errors in panel C apply for questions in the survey core, while those in panel D apply to questions in the survey supplement. In each case, we show the standard error when all HS/EHS programs are analyzed, and when HS programs and EHS programs are reported separately. For questions in the core survey, results are also reported for Region XI and Region XII, so those standard errors are also shown in panels A and B in the last two columns.

To illustrate the use of the lookup table, consider results in Chapter Three, where the health manager is the unit of analysis. Regardless of the estimated percentage, the standard error for responses among all health managers (HS/EHS programs combined) is approximately 1 percentage point (i.e., 100 times the standard error shown in the table). Thus, the 95 percent confidence interval for a given percentage would be plus or minus 2 percentage points (i.e., the standard error times 1.96). The standard error is also approximately 1 percentage point for survey responses based on health managers in HS programs. For responses based on health managers in EHS programs, the standard error is approximately 1 percentage point for percentages ranging from 0 to 25 percent or 75 to 100 percent, and about 2 percentage points for percentages ranging from 25 percent to 75 percent. Because of the smaller number of respondents in Region XI and Region XII programs, the approximate standard errors are larger, ranging from 3 to 6 percentage points for Region XI and 3 to 7 percentage points for Region XII. Thus, in these two regions, the 95 percent confidence interval will be plus or minus 6 to 12 percentage points in Region XI and 6 to 14 percentage points for Region XII, depending on the value of p. The estimated standard errors are very similar in panel C for core survey questions when the program is the unit of analysis.

Table B.8. Approximate Standard Errors for Survey Percentages: By Program Type

Percentage Values	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
A. Health Manager as Unit of Analysis—Core Questions					
5 percent or 95 percent	0.01	0.01	0.01	0.03	0.03
10 percent or 90 percent	0.01	0.01	0.01	0.03	0.04
15 percent or 85 percent	0.01	0.01	0.01	0.04	0.05
20 percent or 80 percent	0.01	0.01	0.01	0.05	0.06
25 percent or 75 percent	0.01	0.01	0.02	0.05	0.06
30 percent or 70 percent	0.01	0.01	0.02	0.05	0.07
35 percent or 65 percent	0.01	0.01	0.02	0.05	0.07
40 percent or 60 percent	0.01	0.01	0.02	0.06	0.07
45 percent or 55 percent	0.01	0.01	0.02	0.06	0.07
50 percent	0.01	0.01	0.02	0.06	0.07
Maximum *N*	1,465	1,264	795	76	46
B. Health Manager as Unit of Analysis—Supplement Questions					
5 percent or 95 percent	0.01	0.01	0.02	–	–
10 percent or 90 percent	0.02	0.02	0.02	–	–
15 percent or 85 percent	0.02	0.02	0.02	–	–
20 percent or 80 percent	0.02	0.02	0.03	–	–
25 percent or 75 percent	0.02	0.02	0.03	–	–
30 percent or 70 percent	0.02	0.03	0.03	–	–
35 percent or 65 percent	0.02	0.03	0.03	–	–
40 percent or 60 percent	0.03	0.03	0.03	–	–
45 percent or 55 percent	0.03	0.03	0.03	–	–
50 percent	0.03	0.03	0.03	–	–
Maximum *N*	376	331	205	–	–
C. Program as Unit of Analysis—Core Questions					
5 percent or 95 percent	0.005	0.01	0.01	0.02	0.03
10 percent or 90 percent	0.01	0.01	0.01	0.03	0.04
15 percent or 85 percent	0.01	0.01	0.01	0.04	0.05
20 percent or 80 percent	0.01	0.01	0.01	0.04	0.06
25 percent or 75 percent	0.01	0.01	0.02	0.04	0.06
30 percent or 70 percent	0.01	0.01	0.02	0.05	0.07
35 percent or 65 percent	0.01	0.01	0.02	0.05	0.07
40 percent or 60 percent	0.01	0.01	0.02	0.05	0.07
45 percent or 55 percent	0.01	0.01	0.02	0.05	0.07
50 percent	0.01	0.01	0.02	0.05	0.07
Maximum *N*	1,902	1,176	726	101	48
D. Program as Unit of Analysis—Supplement Questions					
5 percent or 95 percent	0.01	0.01	0.02	–	–
10 percent or 90 percent	0.01	0.02	0.02	–	–
15 percent or 85 percent	0.02	0.02	0.03	–	–
20 percent or 80 percent	0.02	0.02	0.03	–	–
25 percent or 75 percent	0.02	0.03	0.03	–	–
30 percent or 70 percent	0.02	0.03	0.03	–	–
35 percent or 65 percent	0.02	0.03	0.03	–	–
40 percent or 60 percent	0.02	0.03	0.04	–	–
45 percent or 55 percent	0.02	0.03	0.04	–	–
50 percent	0.02	0.03	0.04	–	–
Maximum *N*	486	300	186	–	–

SOURCE: Authors' calculations.

NOTES: In the case of the Health Manger Survey supplements, we based the standard-error estimate on the largest sample across the four supplements (see Table B.4). – = not applicable (results not reported by region for questions in the supplement).

For survey questions in the supplement, because the number of respondents is about one-fourth as large as the number of respondents for core survey questions, the standard errors will be larger. Table B.8 shows that the standard errors are about 2 to 3 percentage points for all HS/EHS programs and all HS programs and about 2 to 4 percentage points for all EHS programs. This means the 95 percent confidence interval will be plus or minus 4 to 8 percentage points, depending on which programs are examined. Because the number of respondents in the supplement in Regions XI and XII are quite small (see Table B.4), we do not report results separately for programs in those regions when a questions is in the supplement. If we did, the standard errors for estimates for those two regions would almost double, with a range from 5 to 13 percentage points, depending on the value of *p* (i.e., 95 percent confidence intervals that are plus or minus 10 to 26 percentage points, compared with plus or minus 6 to 14 percentage points for questions in the survey core).

Standard Errors for Survey Tabulations in Appendix F

Appendix F provides supplemental survey tabulations that compare responses to questions in the Health Manager Survey core (asked of all respondents), disaggregated by subgroups, defined by health manager health-related background, program size, and the degree of urbanicity where the program centers are located. Tables B.9, B.10, and B.11 report the standard errors associated with percentages for each of these subgroup analyses, with the same interpretation as the examples provided with Table B.8.

Table B.9. Approximate Standard Errors for Survey Percentages: By Program Size

	Program Size		
Percentage Values	**Small**	**Medium**	**Large**
5 percent or 95 percent	0.01	0.01	0.01
10 percent or 90 percent	0.01	0.01	0.01
15 percent or 85 percent	0.01	0.01	0.01
20 percent or 80 percent	0.02	0.02	0.02
25 percent or 75 percent	0.02	0.02	0.02
30 percent or 70 percent	0.02	0.02	0.02
35 percent or 65 percent	0.02	0.02	0.02
40 percent or 60 percent	0.02	0.02	0.02
45 percent or 55 percent	0.02	0.02	0.02
50 percent	0.02	0.02	0.02
Maximum *N*	593	643	656

SOURCE: Authors' calculations.

Table B.10. Approximate Standard Errors for Survey Percentages: By Health Manager Background

	Health Manager Health-Related Education Background		
Percentage Values	**No Degree**	**Associate**	**Bachelor's**
5 percent or 95 percent	0.01	0.01	0.01
10 percent or 90 percent	0.02	0.01	0.01
15 percent or 85 percent	0.02	0.02	0.01
20 percent or 80 percent	0.03	0.02	0.01
25 percent or 75 percent	0.03	0.02	0.01
30 percent or 70 percent	0.03	0.02	0.01
35 percent or 65 percent	0.03	0.02	0.01
40 percent or 60 percent	0.03	0.02	0.01
45 percent or 55 percent	0.03	0.02	0.02
50 percent	0.03	0.02	0.02
Maximum *N*	236	467	1,068

SOURCE: Authors' calculations.

Table B.11. Approximate Standard Errors for Survey Percentages: By Urban-Rural Status

	Rural-Urban Status		
Percentage Values	**Mostly Rural**	**Mixed**	**Mostly Urban**
5 percent or 95 percent	0.02	0.01	0.01
10 percent or 90 percent	0.02	0.01	0.01
15 percent or 85 percent	0.03	0.01	0.01
20 percent or 80 percent	0.03	0.02	0.01
25 percent or 75 percent	0.03	0.02	0.01
30 percent or 70 percent	0.03	0.02	0.01
35 percent or 65 percent	0.03	0.02	0.01
40 percent or 60 percent	0.04	0.02	0.02
45 percent or 55 percent	0.04	0.02	0.02
50 percent	0.04	0.02	0.02
Maximum *N*	193	675	1,030

SOURCE: Authors' calculations.

Appendix C. Semistructured Interview Methods

This appendix provides additional detail about the methods used to collect and analyze the qualitative information collected through semistructured interviews with health managers and other HS/EHS program staff (teachers, family service workers, and home visitors). In particular, this appendix details aspects related to the data collection (protocol development and training), response totals and rates, and the characteristics of the health manager interview respondents. The interview protocols are found in Appendix E.

Protocol Development and Interviewer Training

Two interview protocols—one for health managers and one for teachers and other staff—were developed, guided by the study organizational framework (see Figure 1.1) and the topics covered in the online survey instrument. The content and wording of the draft interview protocols were we reviewed with OHS, and the federal project officer, and members of the project TWG.

The interviewers participated in a two-hour training, led by RAND experts on qualitative-data collection. The training topics covered consent procedures, rights in research, the framing of questions for respondents' ease and comfort with candid questions, and the use of probes. The training included some opportunity to practice with the interview protocol. Once in the field, the first few interviews were conducted in pairs to ensure that the protocols were working as intended, that individuals were interpreting the questions as intended, and that the length of the interview was consistent with our target. No edits to the interview protocols were made as a result, because respondents were able to understand and answer the questions. After that, the team split up, and each interview was conducted in by a single interviewer. All interviews were phone-based, and the interviewer took notes via computer during the interview; interviews were not recorded. As the interviews were nearing completion, the team received training in Atlas.ti, the software used for interview coding.

Response Totals

Table 2.4 in Chapter Two reported a total of 38 health manager interviews and 52 interviews with other staff, for a response rate of 59 percent and 43 percent, respectively. Table C.1 shows the total number of respondents in the two categories invited to participate in the survey and the interview disposition. Using the AAPOR (2015) metrics, the refusal rate was very low (less than 2 percent), and the cooperation rate was very high (about 93 percent for health managers and 81 percent for other staff). Two health manager interviews and eight staff member interviews could not be completed before the end of the field period. Given our target number of interviews to conduct in each category (40 health managers and 60 other staff), the response rate treats invited

participants as not eligible if they agreed to an interview but were in process when the target was reached.

Table C.1. Response Rates for Interviews with Health Managers and Other Staff

Measures	Survey Respondent	
	Health Managers	Other Staff
Invited to participate in an interview (*N*)	85	147
Did not consent to interview	1	0
Contact information not valid	0	4
Did not respond to request for interview	24	57
Could not complete the interview before end of field period	2	8
Total nonresponse	27	69
Completed interview	38	52
Total response	38	52
Agreed to interview but target reached	20	26
Total not eligible	20	26
Cooperation rate (%)	92.7	81.3
Refusal rate (%)	1.5	0.0
Response rate (%)	58.5	43.0

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's interviews with health managers and other staff (teachers, family service workers, and home visitors).
NOTES: Results are unweighted. Rates correspond to AAPOR (2015) rates as follows: cooperation rate 1, refusal rate 3, and response rate 3.

Characteristics of Health Manager Interview Respondents

Table C.2 shows the characteristics of the health managers in our interview sample based on their online Health Manger Survey responses, which the table compares with the weighted characteristics of the health manager workforce, as reported in Chapter Three, based on all respondents to the online Health Manager Survey. This allows us to determine how representative our interview sample is of the entire health manager workforce. Overall, given that we interviewed 38 individuals, we have a very representative sample of interview respondents in terms of gender, age, ethnicity, race, and education level, with interview respondents in almost all categories of the demographic variables. The one exception is years of experience, where our interview sample is overrepresented among those with 11 to 25 years of experience.

Table C.2. Characteristics of Health Manager Interview Respondents and Online Health Manager Survey Respondents

	Health Manager Interview Respondents		Online Health Manager Survey Respondents
Measures	**Number**	**Percentage**	**Percentage**
Sex			
Female	36	97.2	95.6
Male	1	2.7	4.3
[Missing]	*1*	*2.6*	*10.0*
Age			
Younger than age 25	0	0.0	1.0
25 to 34	7	18.9	15.0
35 to 44	7	18.9	25.9
45 to 54	16	43.2	31.4
55 to 64	5	13.6	22.4
65 or older	2	5.4	4.4
[Missing]	*1*	*2.6*	*9.8*
Hispanic, Latino/a, or Spanish origin			
No	32	86.4	85.7
Yes	5	13.6	15.3
[Missing]	*1*	*2.6*	*10.3*
Race			
White	31	83.8	78.2
Black or African American	5	13.6	16.0
American Indian or Alaska Native	3	8.1	5.4
Asian or South Asian	1	2.7	2.8
Other	0	0.0	0.8
[Missing]	*1*	*2.6*	*9.5*
Highest education level			
Up to high school diploma/GED	0	0.0	1.8
Vocational/technical diploma	3	8.3	6.6
Some college, no degree	1	2.7	6.4
Associate degree	8	22.3	19.2
Bachelor's degree	12	33.4	36.2
Graduate/professional school, no degree	2	5.6	7.2
Master's degree	10	27.8	20.9
Other postgraduate degree	0	0.0	1.8
[Missing]	*2*	*5.3*	*9.2*
Years of experience in Head Start			
Less than 2 years	0	0.0	11.1
3 to 5 years	4	12.5	8.3
6 to 10 years	0	0.0	13.2
11 to 25 years	25	75.0	18.4
26 or more years	4	12.5	39.5
[Missing]	*4*	*11.1*	*17.8*
Number of health manager respondents	38		1,465

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey and health manager interviews. See Tables 3.1, 3.2, and 3.6 for results for full survey sample.

NOTES: Results for the 38 interview respondents are unweighted and based on the survey responses for the 38 health managers who completed the semistructured interviews. The results for the health manager interview sample are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for each measure for reference.

Appendix D. Director and Health Manager Survey Online Instruments

The online Director Survey and the online Health Manager Survey questionnaires are annotated to show headers for each module and with notes to clarify how the questions displayed in the online version of the survey (in capital italics) and to indicate the skip patterns. These headers and instructional text did not appear in the online MMIC survey instruments. See Chapter Two and Appendix A for addition details on the online surveys.

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Head Start Heath Manager Descriptive Study
Online Head Start Director Survey Questionnaire

WELCOME PAGE

Welcome to the Head Start Health Managers Descriptive Study - Head Start Director Survey.

The Office of Head Start, Administration for Children and Families (ACF) within the Department of Health and Human Services (DHHS), is funding a Head Start Health Managers Descriptive Study. This study is being conducted by the RAND Corporation.

The purpose of the Head Start Health Managers Descriptive Study is to provide a current snapshot of health-related activities and programming within Early Head Start (EHS), Head Start (HS), Migrant and Seasonal (MSHS), and American Indian and Alaska Native (AIAN) programs. Your responses to this survey will provide important information about:

- The characteristics and responsibilities of health managers and other stakeholders;
- The current landscape of health programs and services being offered to children and families;
- Procedures for how health initiatives are prioritized, implemented, and sustained;
- Facilitators and barriers to providing health-related services, support, and education to children, families and staff.

The survey will take about 15 minutes to complete. If you do not have time to complete the survey in one sitting, you can come back to it later by following your personalized link provided in the email invitation or by going to the survey website and entering your user name and password (also in the email invitation).

For the best survey experience, please use the "Next" and "Back" buttons in the survey and not the ones in your browser. Every time you click "Next" your response is saved. At the end of the survey, you will be given the option to print a hard copy for your records.

Thank you for your participation!

EXPLANATION AND CONSENT FOR DIRECTOR SURVEY

The Office of Head Start, Administration for Children and Families (ACF) within the Department of Health and Human Services (DHHS), is funding a Head Start Health Managers Descriptive Study. This study is being conducted by the RAND Corporation. The purpose of the study is to provide a current snapshot of health-related activities and programming within Early Head Start (EHS) and Head Start (HS) programs, to better understand the context in which the health services area operates, and to identify the current needs of health managers and health staff as they work towards improving the health of HS children, parents and staff. The objectives of the survey are to:

- Describe the characteristics of health managers and related staff in HS and EHS programs;
- Identify the current landscape of health services being offered to children and families;
- Determine how health initiatives are prioritized, implemented, and sustained; and
- Identify the programmatic features and policy levers that exist to support health services including staffing, environment, and community collaboration.

This study is descriptive; it is not designed to capture individual child or family data or performance standards compliance. Data from this study will not be used for monitoring purposes. Instead this study will provide the Office of Head Start with a picture of what Head Start programs are working on and the areas in which further assistance may be needed.

As part of this study, we are asking all program directors to complete a short, 15-minute on-line survey that will provide us with some basic information about your program. We will also ask you to provide the name and contact information for your program's health manager, who will then receive an invitation to participate in an on-line survey for health managers. The survey allows you to stop and save your responses at any time and return to them later for completion.

The risk to participation in this study is minimal. In any written reports of the data obtained from this survey, your responses will be combined with others and reported together. If quotations are used in any reports, they will not be connected to an individual or grantee. Identifiable information that you provide (e.g., name, program) will not be shared with anyone outside of the RAND project staff without your permission, except as required by law. At the end of the study, we will destroy any information that identifies you as a participant. There may be questions for which you do not have answers, but as stated earlier, we will not identify your name in any report.

Although there are no direct benefits to you for answering the following questions, your participation in this study will provide information that will help Head Start improve the health services area and the support that you receive to enhance your health programming. You will be able to print or save a copy of your responses to the survey for your own records.

Taking part in this survey is voluntary and you may choose to skip any questions that you do not want to answer. While your participation is voluntary, we do hope you will decide to contribute to this important study. Your participation is extremely important to ensure that we capture what is occurring in all Head Start programs.

If you have any questions or comments about the study please contact Lynn Karoly (Lynn_Karoly@rand.org, 703-413-1100 x 5359) or Laurie Martin (Laurie_Martin@rand.org, 703-413-1100 x 5083). If you have any questions about your rights as a research participant, you may contact Tora Bikson, Administrator, RAND Human Subjects Protection Committee by phone at (310)393-0411 or by email: Tora_Bikson@rand.org.

Do you agree to participate in this study?

1. Yes → [PROCEED TO SURVEY]
2. No → [*TO CLOSING SCREEN:* Thank you for your consideration.]

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0970-0415. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

MODULE 1. PROGRAM AND HEALTH SERVICES AREA BACKGROUND

Thank you for agreeing to take part in this study. The questions that follow will help us learn a bit more about your EHS/HS program. We would also like your help in identifying the most appropriate staff member to complete the Health Manager Survey.

We use the term "health services area" to mean things that relate to physical health and safety, behavioral health and oral health. All questions in this survey refer to Head Start (HS), Early Head Start (EHS), Migrant Seasonal (MS), and American Indian and Alaska Native programs (AIAN), but we refer to EHS/HS for brevity.

Our records show that you are the director for the following program(s) defined by their grant number, delegate number, program type, and program name.

Please check yes if you currently direct these programs, check no if you do not. If there are any other programs that you direct, please fill out the grid below.

Grant No.	Delegate No.	Program Type	Program Name	Are you the director? 1. Yes 2. No
'grant number'	'delegate number'	'program type'	'program name'	1 2
'grant number'	'delegate number'	'program type'	'program name'	1 2
				1 2
				1 2

As part of the Head Start Health Manager Study, we would like to invite the health manager(s) for your EHS/HS program(s) to complete a Health Manager Survey that will obtain more detailed information about the health component that they manage. By providing their contact details, you do not obligate them to participate in the study. Please list name, email address, and phone number of the person who is responsible for the health services area of your EHS/HS program. Often this individual has the title of "health manager." Please indicate if you use a different title. Also, please check all grants that this health manager serves. If there is more than one health manager for your program(s), you will be given the option to provide the name and contact information for additional health manager(s) on the next page.

DIR1_name. Health manager name	
DIR1_Email. Email	
DIR1_PhoneA. Office Phone	
DIR1_Job_Title. Job Title: **DIR1_Job_Title_other**.	1. Health manager 2. Other (specify) _____
DIR1_applicable_grants. Applicable grants (check all that apply)	

DIR1. Do you have additional health managers for your program(s) that you have not already entered?

1. Yes
2. No

IF DIR1 = Yes RETURN TO GRID TO ENTER NAME, ETC.; ELSE CONTINUE TO DIR5.

The next four questions are about your overall program budget and specifically about the budget for the health component. We will ask these questions for each grant you currently direct. Again, all your responses are confidential and will not be shared with anyone.

Please answer these questions with respect to the following grant: [*FILL*]

DIR5. What is the **total operating budget** (federal plus non-Federal) for your EHS/HS program for the current grant year?

Grant start month and year (mo/yr)_____/ _____

Grant end month and year (mo/yr)_____/ _____

Total operating budget: $_____.00 (***Please do not enter commas or punctuation***)

DIR6. What is the total budget (federal plus non-Federal) for the health component in the current grant year?

Total health component budget: $_____ (Please do not enter commas or punctuation)

DIR7. What happens if the need for treatment exceeds the designated budget?

_____(open ended)

DIR8. Provide your best estimate for the proportion of your health budget that goes towards covering out of pocket costs incurred by uninsured or underinsured families.

Percent: _____%

DIR3. Are you involved in any of the following activities related to the Health Services Advisory Committee (HSAC)? ***Check all that apply***.

1. Identifying potential members
2. Selecting members
3. Providing input on committee activities
4. Scheduling committee activities
5. Attending committee meetings
6. Other (specify) _____

---

7. No involvement

DIR4. EHS/HS programs face many challenges in serving high need or high risk families. Which, if any, of the following special populations do you serve? ***Check all that apply***.

1. Homeless families
2. Teen parents
3. Children with disabilities
4. Children in foster care
5. Military families
6. American Indian and Alaska Native
7. Migrant and seasonal families
8. Others? (please specify) _____

---

9. Do not serve any special populations
10. Don't know

MODULE 2. DIRECTOR BACKGROUND

Now we have a few questions about your educational background and work experience.

DED01. What is the highest grade or year of school that you completed? ***Select one***.

1. Less than a high school diploma/equivalent (GED)
2. High School Diploma/Equivalent (GED
3. Vocational/Technical Program After High School But No Vocational/Technical Diploma
4. Vocational/Technical Diploma After High School
5. College Coursework But No Degree
6. Associate Degree
7. Bachelor's Degree
8. Graduate Or Professional School But No Degree
9. Master's Degree (MA, MS, MPH, MSN)
10. Doctorate Degree (Ph.D., Ed.D.)
11. Other Postgraduate Degree (Medicine/MD; Dentistry/DDs; Law/JD/Llb; Etc.)

DED02. Please describe how much coursework you had in the following areas? ***Select one response per row.***

AREA	*RESPONSE CODES* 1. I have not completed any course work in this area 2. I completed a few courses 3. I received an AA or completed a certificate program in this area 4. I received a BA in this area (e.g., major, minor, concentration) 5 I received my master's, doctorate or other postgraduate degree in this area				
a. Child health and development	1	2	3	4	5
b. Children with special health care needs/disability	1	2	3	4	5
c. Medicine	1	2	3	4	5
d. Nursing	1	2	3	4	5
e. Behavioral or mental health (e.g., counseling, family therapy)	1	2	3	4	5
f. Social work	1	2	3	4	5
g. Health education	1	2	3	4	5
h. Nutrition	1	2	3	4	5
i. Physical fitness/physical education	1	2	3	4	5
j. Public health/community health	1	2	3	4	5
k. Other health topic (specify_____)	1	2	3	4	5

DED03. Have you ever had any certificates, credentials, or state awarded licenses pertaining to health such as medicine, nursing, social work, or health education? ***Select one***.

1. Yes
2. No

IF DED03 = No GO TO DED05; ELSE CONTINUE TO DED04.

DED04. For each one that you have had, say whether it is active at this time. ***Check all that apply*.**

LICENSE/CERTIFICATION	*RESPONSE CODES* 1. Yes, it is active at this time 2. No, I had one but it is not active now 3. Not applicable
a. A license as a physician (MD)	1 2 3
b. A license as an osteopath (DO)	1 2 3
c. A license as a registered nurse (RN)	1 2 3
d. A license as a licensed practical nurse (LPN)	1 2 3
e. A licensed vocational nurse	1 2 3
f. A certification as a nurse practitioner (NP)	1 2 3
g. A certification as a school nurse	1 2 3
h. A certification or license as a social worker	1 2 3
i. A certification or license as a counselor	1 2 3
j. A certification or license as a psychologist	1 2 3
k. A license as a psychiatrist	1 2 3
l. A license as a dentist	1 2 3
m. A certification or license as a dental hygienist	1 2 3
n. A certification or license as a nutritionist	1 2 3
o. Other license, certificate or credential (Please specify) _____	1 2 3

DED05. Counting this program year, how many years have you ever worked . . . Note: you may have the same answer for more than one row. ***Select one response per row.***

WORK HISTORY	*RESPONSE CODES* 1. No experience of this type 2. Less than 1 year 3. 1–2 years 4. 3–5 years 5. 6–10 years 6. 11–24 years 7. 25 years or more
a. With children under 6 years of age in any child care or education setting? (Include years as child care provider, teacher, director, etc., for EHS/HS and non-Head Start settings, but do not include years spent raising your own children.)	1 2 3 4 5 6 7
b. In any EHS/HS programs? (Include MSHS and AIAN)	1 2 3 4 5 6 7
c. In any Migrant and Seasonal (MSHS) EHS/HS programs, specifically?	1 2 3 4 5 6 7
d. In any American Indian or Alaska Native (AIAN) EHS/HS programs, specifically?	1 2 3 4 5 6 7
e. As a health manager in an EHS/HS program?	1 2 3 4 5 6 7
f. In a health care setting, such as a community health clinic or school-based health center?	1 2 3 4 5 6 7

DED06 Aside from your responsibilities as program director, do you have other responsibilities with this EHS/HS program? ***Select one.***

1. Yes
2. No

IF DED06 = YES GO TO DED07; ELSE CONTINUE TO DED08.

DED07. Other than your responsibilities as director, what other responsibilities do you have with EHS/HS? ***Check all that apply***.

1. Teacher
2. Teacher's aide/instructional aide
3. Education coordinator
4. Family service worker/home visitor
5. Outreach staff/recruiter/enrollment coordinator
6. Counselor
7. Disability coordinator
8. Parent involvement coordinator
9. Behavioral health (or mental health) coordinator
10. Nutrition coordinator
11. Culinary or food services staff
12. Receptionist/office staff
13. Bus driver or related transportation
14. Center director, associate center director, or other program manager
15. Other, specify _____

16. No additional responsibilities

DED08. Before the position you have now, what other positions have you held at your program now or another EHS/HS program? ***Check all that apply***.

1. Health manager
2. Health coordinator
3. Teacher
4. Teacher's aide/instructional aide
5. Education coordinator
6. Family service worker/home visitor
7. Outreach staff/recruiter/enrollment coordinator
8. Counselor
9. Disability coordinator
10. Parent involvement coordinator
11. Behavioral health (or mental health) coordinator
12. Nutrition coordinator
13. Culinary or food services staff
14. Receptionist/office staff
15. Bus driver or related transportation
16. Center director, associate center director, or other program manager
17. Other (Specify) _____

18. None—no previous positions

In this final section, we have a few questions about your background including what languages you speak, read, or understand.

DDM01. What is your sex? ***Select one***.

1. Male
2. Female

DDM02. Are you Hispanic, Latino/a, or Spanish origin? ***One or more categories may be selected.***

a. No, not of Hispanic, Latino/a, or Spanish origin
b. Yes, Mexican, Mexican American, Chicano/a
c. Yes, Puerto Rican
d. Yes, Cuban
e. Yes, another Hispanic, Latino, or Spanish origin

DDM03. What is your race? ***One or more categories may be selected.***

a. White
b. Black or African American
c. American Indian or Alaska Native
d. Asian Indian
e. Chinese
f. Filipino
g. Japanese
h. Korean
i. Vietnamese
j. Other Asian
k. Native Hawaiian
l. Guamanian or Chamorro
m. Samoan
n. Other Pacific Islander

DDM04. How well do you speak English? ***Select one***.

1. Very well
2. Well
3. Not well
4. Not at all

DDM05. Do you speak a language other than English at home? ***Select one***.

1. Yes, please specify other language: _____
2. No

DDM07. Is your age…? ***Select one.***

1. Under age 25
2. 25 to 34
3. 35 to 44
4. 45 to 54
5. 55 to 64
6. 65 or older

DDM08. Do you or did you ever have a child in your household who attends/attended EHS/HS? ***Select one***.

1. Yes
2. No

DDM10. Is there anything else that you would like to share about the health services area or health needs of the children and families in your program?

_____ *(OPEN ENDED)*

Thank you for completing this survey. We know you are very busy and we appreciate the time and thought you put into your responses.

As a reminder, you may want to print a copy of your responses for your records as you will not be able to access your survey once it has been submitted. Please click here to display a screenshot of your responses (the page may take a few moments to load). Then, you will be able to print the screenshot page using your browser's print function. Please note that sensitive information (e.g., names, emails, phone numbers) will not be included in the screenshots.

Updates regarding the Head Start Health Manager Study, including study reports, will be available here on the project website.

Please click the "Next" button below to submit your survey responses.

Please note that by clicking on the NEXT button, your survey will be considered complete and you will not be able to return to earlier responses to make changes.

OMB number: 0970-0415
Expiration date 11/30/2013

Head Start Heath Manager Descriptive Study
Online Head Start Health Manager Survey Questionnaire

WELCOME PAGE

Welcome to the Head Start Health Managers Descriptive Study - Head Start Health Manager Survey.

The Office of Head Start, Administration for Children and Families (ACF) within the Department of Health and Human Services (DHHS), is funding a Head Start Health Managers Descriptive Study. This study is being conducted by the RAND Corporation.

The purpose of the Head Start Health Managers Descriptive Study is to provide a current snapshot of health-related activities and programming within Early Head Start (EHS), Head Start (HS), Migrant and Seasonal (MSHS), and American Indian and Alaska Native (AIAN) programs. Your responses to this survey will provide important information about:

- The characteristics and responsibilities of health managers and other stakeholders;
- The current landscape of health programs and services being offered to children and families;
- Procedures for how health initiatives are prioritized, implemented, and sustained;
- Facilitators and barriers to providing health-related services, support, and education to children, families and staff.

The survey will take about 75 minutes to complete, which includes the time it may take you to look up information or to ask other staff for input on certain questions. If you do not have time to complete the survey in one sitting, you can come back to it later by following your personalized link provided in the email invitation or by going to the survey website and entering your user name and password (also in the email invitation).

For the best survey experience, please use the "Next" and "Back" buttons in the survey and not the ones in your browser. Every time you click "Next" your response is saved. At the end of the survey, you will be given the option to print a hard copy for your records.

Thank you for your participation!

EXPLANATION AND CONSENT FOR HEALTH MANAGER SURVEY

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- Describe the characteristics of health managers and related staff in HS and EHS programs;
- Identify the current landscape of health services being offered to children and families;
- Determine how health initiatives are prioritized, implemented, and sustained; and

- Identify the programmatic features and policy levers that exist to support health services including staffing, environment, and community collaboration.

This study is descriptive; it is not designed to capture individual child or family data or performance standards compliance. Data from this study will not be used for monitoring purposes. Instead this study will provide the Office of Head Start with a picture of what Head Start programs are working on and the areas in which further assistance may be needed.

As part of this study, we are asking all health managers to complete an on-line survey that will provide us with some basic information about your program. We will also ask you to provide the name and contact information for your program's health manager, who will then receive an invitation to participate in an on-line survey for health managers. The survey allows you to stop and save your responses at any time and return to them later for completion.

The risk to participation in this study is minimal. In any written reports of the data obtained from this survey, your responses will be combined with others and reported together. If quotations are used in any reports, they will not be connected to an individual or grantee. Identifiable information that you provide (e.g., name, program) will not be shared with anyone outside of the RAND project staff without your permission, except as required by law. At the end of the study, we will destroy any information that identifies you as a participant. There may be questions for which you do not have answers, but as stated earlier, we will not identify your name in any report.

Although there are no immediate benefits to you for answering the following questions, results from this study are likely to yield benefits to you in the future in your role as health manager. Your participation in this study will provide important information that will help Head Start improve the health services area and the support that you receive to enhance your health programming. As a benefit to you, you will be able to print or save a copy of your responses to the survey for your own records. However, given that this material may contain your opinions and thoughts of the health services area of your EHS/HS program that you may not want others to see, please be cautious when printing your responses, or when saving them to a business or public/shared computer to ensure your privacy.

Taking part in this survey is voluntary and you may choose to skip any questions that you do not want to answer. While your participation is voluntary, we do hope you will decide to contribute to this important study. Your participation is extremely important to ensure that we capture what is occurring in all Head Start programs.

If you have any questions or comments about the study please contact Lynn Karoly (Lynn_Karoly@rand.org, 703-413-1100 x 5359) or Laurie Martin (Laurie_Martin@rand.org, 703-413-1100 x 5083). If you have any questions about your rights as a research participant, you may contact Tora Bikson, Administrator, RAND Human Subjects Protection Committee by phone at (310) 393-0411 or by email: Tora_Bikson@rand.org.

Do you agree to participate in this study?

1. Yes → [PROCEED TO SURVEY]
2. No → [*TO CLOSING SCREEN:* Thank you for your consideration.]

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0970-0415. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

MODULE 1. KEY STAKEHOLDERS

This first set of questions asks about key stakeholders involved in the health services area of Head Start including the health manager, staff, volunteers, consultants, and the Health Services Advisory| Committee (HSAC). In particular, we are interested in learning more about the staffing model and management of the health program, health training and education opportunities provided to staff, and composition of and interactions with the HSAC.

Throughout the survey, we use the term health services area to mean things that relate to physical health and safety, behavioral health, and oral health. All questions in this survey refer to Head Start (HS), Early Head Start (EHS), Migrant Seasonal (MS), and American Indian and Alaska Native programs (AIAN), but we refer to EHS/HS for brevity. We also use the term "health manager" to mean your position, even though you may have a different title such as health coordinator.

MODULE 1, SECTION 1. HEALTH MANAGER ROLE, STAFFING MODEL, AND

STF01. As the Health Manager, how many EHS/HS sites (or centers) are you responsible for?

_____ Number of centers

STF02. How many hours per week do you usually work for EHS/HS? _____ Hours/Week

STF03. How many weeks per year do you work for EHS/HS? Please include paid vacation time.

_____ Weeks/Year

STF04. Aside from your responsibilities as Health Manager, do you have other responsibilities with this EHS/HS program? ***Select one***.

1. Yes
2. No

IF STF04 = NO, GO TO STF07; ELSE CONTINUE TO STF05.

STF05. Other than your responsibilities as a health manager, what other responsibilities do you have with EHS/HS? ***Check all that apply***.

a. Teacher
b. Teacher's aide/instructional aide
c. Education coordinator
d. Family service worker/home visitor
e. Outreach staff/recruiter/enrollment coordinator
f. Counselor
g. Disability coordinator
h. Parent involvement coordinator
i. Behavioral health (or mental health) coordinator
j. Nutrition coordinator
k. Culinary or food services staff
l. Receptionist/office staff
m. Bus driver or related transportation
n. Center director, associate center director, or other program manager
o. Other (Specify) _____

STF06. What percentage of the hours that you work for EHS/HS is spent managing the health services area (this can include time planning health activities, supervising other health staff, maintaining budgets, etc.)?

_____ percent

STF07 (Supplement A). Below is a list of tasks that a health manager, other EHS/HS staff, or an outside consultant might do. Please select whether you, or someone else is primarily responsible for each task. ***Select one response per row.***

TASKS		*RESPONSE CODES* 1. I am 2. Someone else 3. Not done
a.	Daily health checks of children	1 2 3
b.	Coordinating health screening activities	1 2 3
c.	Conducting health screening/assessments	1 2 3
d.	Coordinating immunizations	1 2 3
e.	Providing immunizations	1 2 3
f.	Medication management of EHS/HS children	1 2 3
g.	Providing acute care/treatment for children, staff, and parents/guardians	1 2 3
h.	Providing counseling/therapeutic services for children and families	1 2 3
i.	Developing Individual Health Plans (IHP)	1 2 3
j.	Making or arranging referrals for health services	1 2 3
k.	Follow-up on health services provided by others (e.g., case management)	1 2 3
l.	Working with direct service providers to establish MOUs, formal partnerships or agreements	1 2 3
m.	Negotiating payments for services paid for by EHS/HS funds	1 2 3
n.	Health curriculum planning	1 2 3
o.	Collect/create health-related resource materials	1 2 3
p.	Ordering health-related supplies (e.g., toothbrushes, first aid kits)	1 2 3
q.	Parent/guardian health education	1 2 3
r.	Teacher/staff training on health issues	1 2 3
s.	Classroom safety/injury prevention	1 2 3
t.	Determining the amount of physical activity and movement in the daily schedule	1 2 3
u.	Monitoring amount of time children spend being physically active	1 2 3
v.	Menu planning	1 2 3
w.	Food purchasing	1 2 3
x.	Food preparation	1 2 3
y.	Helping families access publicly funded insurance (e.g., Medicaid/SCHIP, SCHIP)	1 2 3
z.	Helping families access publicly funded nutrition services (e.g., WIC, SNAP).	1 2 3
aa.	Administrative responsibilities (e.g., reviewing reports for compliance, health record maintenance)	1 2 3
bb.	Completing the PIR	1 2 3
cc.	Monitoring of the health services area budget	1 2 3
dd.	Monitoring of the health services area to meet its stated goals and	1 2 3

objectives	
ee. Other (specify)_____	1 2 3

STF07a (Supplement A). For those tasks that are done by someone else, please tell us who is primarily responsible for that task.

DISPLAY TASKS FROM STF07 WITH RESPONSE CODE 2.

RESPONSE CODES

1. Nutrition coordinator
2. Mental health coordinator
3. Oral health coordinator
4. Disability coordinator
5. Home visitors/family service workers/family advocates
6. Family service coordinator
7. Parent involvement coordinator
8. Education coordinator
9. Teaching staff (including teachers/teacher aide)
10. EHS/HS director
11. Other EHS/HS staff (specify) _____
12. Members of the Health Services Advisory Committee
13. Outside health provider (e.g., oral health, behavioral health, physical health)
14. Other consultant (specify) _____
15. Don't know

STF08 (Supplement A). How often does your program have a regular meeting where the health services area or health-related program activities (e.g., screening days, health education of families) are discussed as either the only focus of or a dedicated part of the meeting agenda? Note: do not include meetings where only the health of an individual child or family is discussed (e.g., IHP meeting). ***Select one***.

1. Never
2. Once a year
3. Twice a year
4. Every two to five months
5. Every month
6. Several times a month
7. Weekly
8. Other (specify)_____

STF09. In your position now, what conditions or situations make it especially hard for you to do your job well? ***Check all that apply.***

a. Time constraints (e.g., not enough time to do all that is required of the health manager position)
b. Poorly defined job responsibilities (e.g., role of health manager is not clear)
c. Not enough support from program leadership for health services area/organizational culture does not prioritize health
d. Too few opportunities to communicate with EHS/HS program director
e. Lack of support staff
f. Not enough training for me (the health manager)
g. Not enough health training for EHS/HS staff
h. Not enough funds for supplies & activities to support health services area

i. Not directly responsible for supervising staff that support the health team
j. Not enough support from the HSAC
k. Too little time with families or inability to maintain sustained contact
l. Difficulty communicating with families due to language or cultural barriers
m. Parent/guardian resistance or reluctance to speak with staff about health issues
n. Parents/guardians not understanding importance of screening/treatment/follow-up
o. Lack of materials at the appropriate literacy/health literacy/reading level
p. Difficulty enrolling families in appropriate health insurance program (e.g., Medicaid/SCHIP)
q. Difficulty accessing health and social service providers on behalf of families
r. Difficulties related to undocumented children and families
s. Having enough resources to serve health needs of children who do not qualify for Part B and C assistance
t. State or local policies (specify)_____
u. Administrative requirements from Office of Head Start (OHS) (federal level)
v. Other (specify) _____

STF10 (Supplement A). Do you or your health staff work with any of the following specialists (a specialist may be working as staff, a volunteer, or a consultant)? ***Check all responses that apply per row.***

STAFF	*RESPONSE CODES* 1. Paid staff 2. Volunteer staff 3. Paid consultant/community partner 4. Volunteer consultant/community partner 5. Do not work with this specialist 6. Don't know 7. Not applicable
a. Social workers	1 2 3 4 9
c. Nurses (RN, LVN, NP)	1 2 3 4 9
d. Physicians/consulting physicians	1 2 3 4 9
e. Physician assistants	1 2 3 4 9
f. Psychiatrists	1 2 3 4 9
g. Psychologists	1 2 3 4 9
h. Parent education specialists	1 2 3 4 9
i. Parent engagement specialists	1 2 3 4 9
j. Counselors	1 2 3 4 9
k. Nutritionists and dieticians	1 2 3 4 9
l. Dentists	1 2 3 4 9
m. Dental hygienists	1 2 3 4 9
n. Early intervention staff	1 2 3 4 9
o. LEA (local education agency) special education staff	1 2 3 4 9
p. Health educators	1 2 3 4 9
q. Public health practitioners	1 2 3 4 9
r. Other staff role (specify)_____	1 2 3 4 9

STF11. Pick the sentence that best describes the languages spoken and understood by EHS/HS health staff. ***Select one.***

1. **All** of the children and families' primary languages are spoken and understood by EHS/HS staff members.
2. **Some** of the children and families' primary languages are spoken and understood by EHS/HS staff members.
3. **None** of the children and families' primary languages are spoken and understood by EHS/HS staff members.

STF12. Do you have teachers, staff members, or consultants who provide guidance on ethnic customs, culture, traditions and values that may relate to the health, behavioral health, and oral health of the children and families in your program? ***Select one***.

1. Yes
2. No
9. Don't know

MODULE 1, SECTION 2. TRAINING AND OTHER PROFESSIONAL DEVELOPMENT

The next questions are about training and other professional development activities you take part in, as well as the training and professional development opportunities available to other EHS/HS staff.

PDV01. First think about training and other professional development activities you have had in the past **three years**. For each topic, please note whether the training was available and if you took it. ***Select one response per row.***

TOPIC	*RESPONSE CODES* 1 = training not available 2 = training available, but I didn't take it 3 = I completed training
Physical Health/Oral Health	
a. Diabetes	1 2 3
b. Overweight and obesity	1 2 3
c. Underweight or stunting or failure to thrive	1 2 3
d. Asthma or other lung disease	1 2 3
e. Vision conditions	1 2 3
f. Hearing conditions	1 2 3
g. Ear infections	1 2 3
h. Lead poisoning	1 2 3
i. Tuberculosis	1 2 3
j. Anemia (e.g., sickle cell, low iron)	1 2 3
k. Infectious diseases	1 2 3
l. Proper use or administration of medication, medical equipment, or medical supports	1 2 3
m. Other physical health problem (specify)	1 2 3
n. Tooth decay or cavities	1 2 3
o. Other dental health problem (specify)_____	1 2 3

Behavioral Health and Developmental Delay		1 2 3
p.	Child neglect or abuse	1 2 3
q.	Family violence	1 2 3
r.	Substance abuse (e.g., alcohol, illicit drugs)	1 2 3
s.	ADHD or ADD	1 2 3
t.	PTSD (post traumatic stress disorder)	1 2 3
u.	Depression	1 2 3
v.	Anxiety (including obsessive-compulsive disorder)	1 2 3
w.	Autism spectrum disorders	1 2 3
x.	Developmental delays (including language delays)	1 2 3
y.	Other behavioral health problem (specify)_____	1 2 3
Prevention and Wellness		1 2 3
z.	General health promotion or wellness	1 2 3
aa.	General child development	1 2 3
bb.	Oral Hygiene (e.g., brushing teeth)	1 2 3
cc.	Immunizations	1 2 3
dd.	Nutrition or healthy eating practices	1 2 3
ee.	Physical activity or fitness	1 2 3
ff.	Food safety	1 2 3
gg.	Injury prevention and safety (e.g., dog bites, motor vehicle safety)	1 2 3
hh.	CPR and other first aid	1 2 3
ii.	Preventing spread of infectious disease (e.g., hand washing, covering mouth when coughing)	1 2 3
jj.	Head lice	1 2 3
kk.	Bed bugs	1 2 3
ll.	Environmental concerns (e.g., pesticide, lead poisoning, second hand smoke)	1 2 3
mm.	Prenatal or postpartum issues	1 2 3
nn.	Emergency preparedness	1 2 3
oo.	Universal precautions	1 2 3
pp.	Health literacy or health communication	1 2 3
qq.	Other prevention or wellness topic (specify)_____	1 2 3

PDV01a. For training you did take, please note whether the training was conducted in your local area (e.g., at your center or elsewhere in the community), outside of your local area, or online. ***Select one response per row.***

DISPLAY TOPICS FROM PDV01 WITH RESPONSE CODE 3.

RESPONSE CODES
1. Local area
2. Outside of local area
3. Online

PDV01b. For training you did take, please note who provided the training.

DISPLAY TOPICS FROM PDV01 WITH RESPONSE CODE 3.

RESPONSE CODES
1. EHS/HS program staff
2. Local organization or community provider (e.g., Red Cross, community college)
3. Trade association or other professional group
4. Office of Head Start (e.g., through training, technical assistance, grantee meetings)

Now we would like you to think about the training and professional development opportunities provided by your program to other staff in your program

PDV02 (Supplement A)**.** In the past three years, has your EHS/HS program provided training, either offsite or onsite, for other EHS/HS staff members (not including you) in. . . ***Check all that apply***.

Physical Health/Oral Health

a. Diabetes
b. Overweight and obesity
c. Underweight or stunting or failure to thrive
d. Asthma or other lung disease
e. Vision conditions
f. Hearing conditions
g. Ear infections
h. Lead poisoning
i. Tuberculosis
j. Anemia (e.g., sickle cell, low iron)
k. Infectious diseases
l. Proper use or administration of medication, medical equipment, or medical supports
m. Other physical health problem (specify)
n. Tooth decay or cavities
o. Other dental health problem (specify)_____

p. No physical health/oral health training provided

Behavioral Health and Developmental Delay

q. Child neglect or abuse
r. Family violence
s. Substance abuse (e.g., alcohol, illicit drugs)
t. ADHD or ADD
u. PTSD (post traumatic stress disorder)
v. Depression
w. Anxiety (including obsessive-compulsive disorder)
x. Autism spectrum disorders
y. Developmental delays (including language delays)
z. Other behavioral health problem (specify)_

aa. No behavioral health and developmental training provided

Prevention and Wellness

bb. General health promotion or wellness
cc. General child development
dd. Oral Hygiene (e.g., brushing teeth)
ee. Immunizations

ff. Nutrition or healthy eating practices
gg. Physical activity or fitness
hh. Food safety
ii. Injury prevention and safety (e.g., dog bites, motor vehicle safety)
jj. CPR and other first aid
kk. Preventing spread of infectious disease (e.g., hand washing, covering mouth when coughing)
ll. Head lice
mm. Bed bugs
nn. Environmental concerns (e.g., pesticide, lead poisoning, second hand smoke)
oo. Prenatal or postpartum issues
pp. Emergency preparedness
qq. Universal precautions
rr. Health literacy or health communication
ss. Other prevention or wellness topic (specify)_____

tt. No prevention and wellness training provided

PDV03. What kinds of things does your EHS/HS program do to make it easier for you or your staff to attend health-related trainings outside of the program? Does it . . . ***Select one response per row.***

ACCOMMODATIONS	*RESPONSE CODES* 1. Yes, for me (health manager) only 2. Yes, for staff only 3. Yes, for me and staff 4. No 9. Don't know
a. Pay staff's registration fees	1 2 3 4 9
b. Pay for travel and lodging	1 2 3 4 9
c. Provide staff coverage	1 2 3 4 9
d. Provide tuition reimbursement for relevant college courses	1 2 3 4 9
e. Any other accommodations (specify) _____	1 2 3 4 9

PDV04. In the past year, how many times did you connect with health managers in other EHS/HS programs to discuss challenges, share strategies and lessons learned, or to seek advice about your program? Note: this can be via phone, email, on-line or in person (e.g., at conferences).

1. I did not connect with other health managers
2. 1–2 times
3. 3–6 times
4. 7 or more times

MODULE 1, SECTION 3. HEALTH SERVICES ADVISORY COMMITTEE

Instructions on screen. Now we would like to learn more about the Health Services Advisory Committee (HSAC) for your program, including who is on it and how it operates.

HSC01. Do you run more than one HSAC?

1. Yes
2. No

[*IF HSC01 = YES, DISPLAY:*

For the following questions, please think about the HSAC that best represents your program (e.g., largest, most well established, has been in existence longer).]

HSC02. How many individuals currently serve on the HSAC for your program?

_____ Number of HSAC members

HSC03. Of these, how many would you consider to be "active" members? These are individuals who regularly engage in their role as a member of the HSAC.

_____ Number of active HSAC members

HSC04. Which of the following groups are represented as members on your HSAC? ***Check all that apply***.

EHS/HS Program Staff

a. Program administrators (e.g., director, associate director, disability coordinator)
b. Family service workers
c. Teachers, teacher's aides, or other classroom staff
d. Nutritionists, nutrition experts
e. Mental health
f. Health educators
g. Other EHS/HS staff (specify)_____

Community Members

h. EHS/HS staff from another program
i. Parents/guardians
j. Medical care providers (e.g., physicians, nurses, medical assistants)
k. Oral health care providers (e.g., dentists, hygienists)
l. Behavioral health providers
m. Disability specialists
n. Migrant health services (or related expertise)
o. Indian Health Service
p. Cultural/community healer (e.g., curandero/a, medicine man/woman)
q. Public health departments/boards of health
r. WIC or other community food or nutrition service
s. Part B and C partners
t. School district LEA or other educational institutions
u. Cultural liaisons (e.g., tribal representatives)
v. Advocacy groups
w. Other social services providers
x. Other local government agencies or officials
y. Other, (specify)_____

HSC05. Do you share an HSAC with another EHS/HS/MSHS/AIAN program? ***Select one.***

1. Yes
2. No

IF HSC05 = NO, GO TO HSC07; ELSE CONTINUE.

HSC06. With which type of Head Start program do you share the HSAC? ***Check all that apply.***

a. EHS program
b. HS program
c. MSHS program
d. AIAN program

HSC07 (Supplement A). Do members of your HSAC have similar racial, ethnic, cultural, and language backgrounds to the children and families you serve? ***Select one.***

1. Yes, members of my HSAC represent all/most of the racial, ethnic, cultural and linguistic backgrounds of the children and families we serve.
2. Yes, members of my HSAC represent some of the racial, ethnic, cultural and linguistic backgrounds of the children and families we serve.
3. No, members of my HSAC do not represent the racial, ethnic, cultural and linguistic backgrounds of the children and families we serve.

HSC08. How often does your HSAC meet? ***Select one***.

1. Never (we do not formally meet as a group)
2. Once a year
3. Twice a year
4. Every two to five months
5. Every month
6. Several times a month
7. Weekly
8. Other (specify)_____

HSC09 (Supplement A). How often do you consult with one or more members of your HSAC apart from regular committee meetings? ***Select one.***

1. Several times a week
2. About once a week
3. About 2–3 times a month
4. About once a month
5. About once every 2–3 months
6. I rarely consult with members of my HSAC apart from our regular meetings.

HSC10 (Supplement A). How strongly do you agree or disagree with the following statements about your HSAC? The HSAC… ***Select one response for each row***.

HSAC STATEMENTS	*RESPONSE CODES* 1. Strongly agree 2. Agree 3. Neither agree nor disagree 4. Disagree 5. Strongly disagree 6. Not applicable
Supporting Your Program	
a. Informs us about current and emergent health issues, trends, and best practices	1 2 3 4 5
b. Develops long- and short-term goals and objectives and strategies for implementing EHS/HS services and activities that meet the needs of the community	1 2 3 4 5
c. Helps to develop health policies and procedures (e.g., policies on how health screenings are conducted, how health activities are implemented that support the health goals for EHS/HS children, families, and staff)	1 2 3 4 5
d. Develops comprehensive health promotion programs for EHS/HS children, families, and staff	1 2 3 4 5
e. Advocates for community systems changes that support the health of the children and families in your program	1 2 3 4 5
f. Helps with or participates in your program's community assessment and ongoing monitoring activities	1 2 3 4 5
Supporting Parents/Guardians	
g. Helps to find continuous, accessible care and treatment services for children and families	1 2 3 4 5
h. Supports parents/guardians in becoming advocates for their children's health	1 2 3 4 5
i. Supports parents/guardians as leaders in efforts to improve the health of their community	1 2 3 4 5
Supporting Community Linkages	
j. Helps to establish ongoing, collaborative partnerships with community organizations	1 2 3 4 5
k. Educates health care providers, other professionals, and community leaders or policymakers on the needs and issues of EHS/HS/MSHS/AIAN children and families	1 2 3 4 5
l. Other (specify)_____	1 2 3 4 5 6

HSC11 (Supplement A). Does your HSAC participate in annual self-assessment of your EHS/HS program's effectiveness? ***Select one***.

1. Yes
2. No

MODULE 1, SECTION 4. PROGRAM POLICIES

These next questions are about some of your program's health-related policies.

POL01 (Supplement A)**.** According to your program's policy, about how many minutes per day should children take part in physical activity? (e.g., on the playground, in the gym, in the classroom, in general)? ***Select one.***

1. Less than 15 minutes
2. 15–29 minutes
3. 30 to 59 minutes
4. 60 or more minutes per day
5. Our program does not have a policy about how many minutes per day children should participate in physical activity

POL02 (Supplement A). Think about how your program prepares children for school. Do you have health-specific goals or objectives that are part of your school readiness plan? ***Select one.***

1. Yes
2. No

POL03 (Supplement A). How do you keep track of the Consumer Product Safety Commission (CPSC) recalls or regulations (e.g., cribs, toys)? ***Check all that apply***.

a. Emails directly from the CPSC
b. Checking the CPSC website
c. The ECLKC
d. Office of Head Start IMS
e. Office of Head Start emails
f. Office of Head Start newsletters
g. Other (specify) _____
h. Don't currently track CPSC recalls or regulations

POL04 (Supplement A). How do you or your program ensure children are not left alone in the classroom, in another part of the facility? ***Check all that apply***.

a. Phones are in all classrooms for staff to call if they need to step out.
b. A count of children entering the classroom is kept and this number is used to count each child as they exit the classroom.
c. Staff conduct a walking and visual sweep of classroom.
d. Staff wait for all children to be ready to leave the bathroom before leaving.
e. Staff count the number of children in the classroom after children have come back from the bathroom.
f. Staff conduct a walking and visual sweep of the bathroom.
g. Staff conduct a walking and visual sweep of the playground.
h. Staff count the number of children before leaving the playground.
i. Staff receive training **at least once a year** in how to ensure children are not left alone.
j. There is no policy or standard guidance provided to staff for making sure children are not left alone.
k. Other (specify) _____
l. My program does not operate in a classroom setting.

POL05 (Supplement A). How do you or your program ensure children are not left alone on the bus or van? ***Check all that apply***.

a. Lines of communication are available (e.g., radio, cell phone) are in all buses/vans for drivers to call if they need to leave the bus/van.
b. A count of children entering the bus/van is kept and this number is used to count each child as they exit the bus.
c. The bus/van driver or bus/van assistant or aide does a walking and visual sweep of the bus, including the floor.
d. A teacher/teacher assistant does a walking and visual sweep of the bus, including the floor.
e. Teachers/teachers assistants receive training **at least once a year** in how to ensure children are not left alone.
f. Bus/van drivers and/or bus/van assistants or aides receive training **at least once a year** in how to ensure children are not left alone.
g. There is no policy or standard guidance provided to teachers or bus/van drivers for making sure children are not left alone.
h. Other_____
i. We do not transport Head Start children.

MODULE 2. HEALTH MANAGEMENT OF INDIVIDUAL CHILD

This next section asks about the health conditions facing children in your program, as well as the amount of time you and your staff spend managing these conditions. We are also interested in learning about your experiences communicating with parents or guardians about specific health concerns. Questions about services you provide to pregnant women will be asked later in the survey.

MODULE 2, SECTION 1. HEALTH CONDITIONS AND HEALTH MANAGEMENT OF

HLT01. What do you see as the major health concerns facing the children and families served by your EHS/HS program? ***Check all that apply.***

Children's Physical Health/Oral Health

a. Diabetes
b. Overweight and obesity (BMI above the 85th percentile)
c. Underweight or stunting or failure to thrive
d. Asthma or other lung disease
e. Vision conditions
f. Hearing conditions
g. Ear infections
h. Lead poisoning
i. Anemia (e.g., sickle cell, low iron)
j. Infectious diseases (e.g., HIV, tuberculosis)
k. Tooth decay or cavities
l. Other health problem (specify)_____

Children's Behavioral Health and Developmental Delay

m. Child neglect or abuse
n. Family violence
o. ADHD or ADD
p. PTSD (post traumatic stress disorder)
q. Depression

r. Anxiety (including obsessive compulsive disorder)
s. Autism spectrum disorders
t. Developmental delays (including language delays)
u. Other behavioral health problem (specify)_____

Family/Adult Physical and Behavioral Health

v. Diabetes
w. Overweight and obesity
x. Asthma or other lung disease
y. Infectious diseases (e.g., HIV, tuberculosis)
z. Family violence
aa. PTSD (post traumatic stress disorder)
bb. Depression
cc. Anxiety (including obsessive compulsive disorder)
dd. Smoking
ee. Alcohol
ff. Prescription drug dependence
gg. Illegal substance/drug dependence
hh. Low health literacy
ii. Other health problem (specify)_____

HLT02 (Supplement B). About how much time per week do you and your staff spend managing these health issues and related complications? This includes time spent providing medication at school, developing individual health care plans including meeting with family, staff training on the issue, communication with health care providers, paper work, monitoring, etc. ***Select one response for each row***.

HEALTH ISSUE	*RESPONSE CODES* 1. Less than half a day per week 2. Between a half day and a full day 3. More than a day a week 4. None. This is not an issue in my program 5. Don't know
Physical Health/Oral Health	
a. Diabetes	1 2 3 4 5
b. Overweight and obesity (BMI above the 85th percentile)	1 2 3 4 5
c. Underweight or stunting or failure to thrive	1 2 3 4 5
d. Asthma or other lung disease	1 2 3 4 5
e. Vision conditions	1 2 3 4 5
f. Hearing conditions	1 2 3 4 5
g. Ear infections	1 2 3 4 5
h. Lead poisoning	1 2 3 4 5
i. Tuberculosis	1 2 3 4 5
j. Anemia (e.g., sickle cell, low iron)	1 2 3 4 5
k. Infectious diseases	1 2 3 4 5
l. Proper use or administration of medication, medical equipment, or medical supports	1 2 3 4 5

m. Other physical health problem (specify) _____	1 2 3 4 5
n. Tooth decay or cavities	1 2 3 4 5
o. Other dental health problem (specify)_____	1 2 3 4 5
Behavioral Health and Developmental Delay	
p. Child neglect or abuse	1 2 3 4 5
q. Family violence	1 2 3 4 5
r. ADHD or ADD	1 2 3 4 5
s. PTSD (post traumatic stress disorder)	1 2 3 4 5
t. Depression	1 2 3 4 5
u. Anxiety (including obsessive compulsive disorder)	1 2 3 4 5
v. Autism spectrum disorders	1 2 3 4 5
w. Developmental delays (including language delays)	1 2 3 4 5
x. Other behavioral health problem (specify)_____	1 2 3 4 5

HLT03 (Supplement B). How many children in your program are not eligible for services under Part B or Part C of the Individuals with Disabilities Education Act, but have chronic health conditions that you feel need additional supports?

_____ children

HLT04 (Supplement B). What health condition(s) require enough additional supports in the EHS/HS program to make you think that condition could make a child eligible for Part B or Part C services? ***Check all that apply.***

a. Diabetes
b. Asthma or other lung disease
c. ADD/ADHD
d. Chronic/recurrent ear infections (otitis media)
e. Premature birth
f. Oral motor/feeding problems
g. Undiagnosed autism (or early indication autism)
h. Neurodevelopmental disorder—not otherwise specified
i. Other health problem (specify) _____

HLT05 (Supplement B). What is the most common method you use to share information about the health of specific children among program staff? ***Select one.***

1. Formal meetings
2. Phone calls
3. Email/electronic communication
4. Written communication to staff (e.g., memos)
5. Entered in staff-accessible child health record or file
6. Other (specify)_____

MODULE 2, SECTION 2. COMMUNICATION WITH PARENTS OR GUARDIANS

For these next questions, please think about how you and your staff communicate with parents or guardians about the health of their child.

PEN01. How often do you or your health team communicate with parents or guardians about their child's health and developmental status, on average? ***Select one.***

1. Never
2. Once a year
3. Twice a year
4. Every two to five months
5. Every month
6. Several times a month
7. Weekly
8. Other (specify)_____

PEN02. What is the most common method you use to share information with parents or guardians about the health of their child? ***Select one.***

1. Formal meetings
2. Phone calls
3. Email/electronic communication
4. Written communication (e.g., notes home)
5. In person communication at drop-off or pick-up
6. Other (specify)_____

PEN03. About how often do you meet with parents or guardians (either by phone or in person) to discuss the health management of a child with special health care needs (e.g., medication management, special supports) apart from daily interactions? Please record an average across children who may have varying special health care needs. ***Select one***.

1. Never
2. Once a year
3. Twice a year
4. Every two to five months
5. Every month
6. Several times a month
8. Other (specify)_____
9. My program does not serve children with special needs

PEN04 (Supplement B). When discussing the health of a child with their parent/guardian, what language is used? ***Select one response per row.***

LANGUAGE	*RESPONSE CODES* 0. Never 1. Sometimes 2. Frequently 3. Always 4. Not applicable 9. Don't know
a. In English if English is the parent or guardian's primary or preferred language	0 1 2 3 4 9

b.	In another language that is the parent or guardian's primary or preferred language (e.g., in Spanish if parent/guardian is Spanish-speaking)	0 1 2 3 4 9
c.	Through an interpreter, to the extent feasible	0 1 2 3 4 9
d.	In English, but English is not the primary or preferred language	0 1 2 3 4 9
e.	Other (specify)_____	0 1 2 3 4 9

PEN05 (Supplement B)**.** Does your program create Individual Family Partnership Agreements (IFPAs) with families specific to reaching health goals? ***Select one.***

1. No
2. Yes
3. Don't know

PEN06 (Supplement B). Which of the following make it most difficult for you to communicate with parents or guardians about the health of their child? ***Check all that apply.***

a. Cultural or religious beliefs or barriers (e.g., male staff should not speak to female caregivers)
b. Language barriers between HS staff and families
c. Not having health-related materials in the appropriate language
d. Literacy barriers (reading ability or health literacy level of parent or guardian is low)
e. Not having health-related materials at an appropriate literacy or reading level
f. Families move a lot/mailing addresses are not current
g. Families change their cell or telephone numbers a lot/phone numbers are not current
h. Parent/guardian does not have a telephone
i. Parent/guardian resistance or reluctance to speak with staff about health issues
j. Parent/guardian does not drop off/pick up (e.g., rides bus), which limits how much I see or talk to families
k. Parent/guardian does not have time
l. Parent/guardian resists or does not understand importance of screening/treatment
m. Lack of staff time to follow-up
n. Other (specify)_____

MODULE 3. SCREENING, REFERRAL AND HEALTH SERVICES PROVIDED

This next set of questions asks about how you get information on the health of children in your program as well as the screening and referral services provided to children in your program. This section also asks about medical care or treatment provided within the HS/EHS program and program linkages with health providers in the community.

MODULE 3, SECTION 1. HEALTH HISTORIES, SCREENING AND REFERRAL

SRF01. Does your program have a process for keeping track of health information about each child in your program? ***Select one***.

1. No
2. Yes, we use an electronic tracking system → SRF01a.
3. Yes, we use a paper/file system
4. Don't know

SRF01a. What is the name of the system that you use for electronic data tracking?

_____

SRF02. Where do you get the information about the health of a child that you put in their health record? ***Check all that apply.***

a. Written records from health providers
b. Interviews/oral history from parent/guardian
c. Written history from parent/guardian
d. Immunization records
e. Written records from teachers
f. Written notes form home visits
g. Child health file from previous child care program
i. Other (specify) _____

SRF03. How often do you update a child's health record? ***Check all that apply.***

a. Once a year
b. Twice a year
c. More than twice a year
d. If/when changes to the child's health occur
e. We don't update the health record

SRF04 (Supplement C). Does your EHS/HS program regularly provide any of the following health screenings to children at no cost to them, in the program? ***Select one response per row.***

HEALTH SCREENINGS	*RESPONSE CODES* 1. Yes, on site 2. Yes, off site 3. Yes, both on and off site 4. No 9. Don't know
a. Blood pressure	1 2 3 4 9
b. Hearing testing	1 2 3 4 9
c. Vision testing	1 2 3 4 9
d. Height and weight measurement (including head circumference, if applicable)	1 2 3 4 9
e. Oral health screening	1 2 3 4 9
f. Lead testing	1 2 3 4 9
g. Tuberculosis testing	1 2 3 4 9
h. Sickle cell anemia testing	1 2 3 4 9
i. Hemoglobin/hematocrit testing	1 2 3 4 9
j. Urinalysis	1 2 3 4 9
k. Behavioral or mental health screening	1 2 3 4 9
l. Cognitive development screening	1 2 3 4 9
m. Social-emotional development screening	1 2 3 4 9
n. Lead screening	1 2 3 4 9
o. Other (specify) _____	1 2 3 4 9

SRF05 (Supplement C). What process(es) do you use to ensure that children receive necessary screenings? ***Check all that apply.***

a. Conducting a periodic review of child health files to ensure that screenings were received
b. Following up with health care providers to obtain copy of health service record
c. Following up with parents/guardians to ensure that screenings were completed
d. Discussing with health staff at regular program meetings
e. Following up with classroom teachers
f. Using an external evaluator to review health records
g. Other (specify_____)

SRF06 (Supplement C). What funds are used to pay for screening? ***Check all that apply***.

a. Medicaid/SCHIP, SCHIP, other publicly funded insurance for children
b. County indigent funds
c. Private insurance
d. Family self-pay, out of pocket expense
e. Grant funding from an external source
f. In-kind contributions from providers
g. EHS/HS program budget
h. Other source (specify) _____
i. Other source (specify)_____

We are now interested in learning about follow-up evaluations including what kinds of things your program does to facilitate those evaluations and how you follow-up to make sure that they have taken place.

SRF07 (Supplement C). How often are the following efforts made to encourage parents or guardians to attend follow-up evaluations? ***Select one response per row.***

SUPPORTS	*RESPONSE CODES* 1. Never 2. Rarely 3. Sometimes 4. Often 5. Always 6. Don't know 7. Not applicable
a. Provide on-site evaluation at EHS/HS center	1 2 3 4 5 6 7
b. Provide information to parents/guardians on what evaluation will entail	1 2 3 4 5 6 7
c. Provide transport to appointments	1 2 3 4 5 6 7
d. Staff (e.g., family advocates) go with families to appointments	1 2 3 4 5 6 7
e. Schedule evaluation time to accommodate parent/guardian schedule	1 2 3 4 5 6 7
f. Provide child care	1 2 3 4 5 6 7
g. Provide interpreters	1 2 3 4 5 6 7
h. Home visits	1 2 3 4 5 6 7
j. Provide help accessing insurance	1 2 3 4 5 6 7
k. Other (specify) _____	1 2 3 4 5 6 7

SRF08 (Supplement C). What process(es) do you use to ensure that children receive follow-up evaluations? ***Check all that apply.***

a. Conduct a periodic review of child health files to ensure that follow-up evaluations were received
b. Follow up with health care providers to obtain copy of health service record
c. Follow up with parents/guardians to ensure that health services were received
d. Discuss with health staff at regular program meetings
e. Follow up with classroom teachers
f. Use an external evaluator to review health records
g. Other (specify_____)

MODULE 3, SECTION 2. MEDICAL AND ORAL HEALTH CARE AND PARTNERSHIPS TO

This next set of questions asks about the medical, dental, and behavioral health care provided to children and families as well as the community partnerships you have for securing services.

MCR01. What types of medical care do health providers who come to the EHS/HS program provide on-site? Consider only actual care or treatment provided by outside providers and not services already provided by EHS/HS staff. ***Check all that apply.***

a. Physical exams
b. Immunizations
c. Oral health prevention (e.g., fluoride)
d. Oral health treatment (e.g., through a mobile or portable dental program)
e. Behavioral or mental health care (e.g., counseling, treatment)
f. Care or therapy for individuals with disabilities (e.g., occupational therapy)
g. Nutritional care (e.g., assistance with feeding tubes)
h. Physical therapy
i. Speech therapy
j. Laboratory services
k. General health education
l. No medical, oral, or behavioral care is provided at our program

MCR02 (Supplement C). How are physical health services usually coordinated with other agencies or community partners? ***Select one***.

1. Formal agreements or memorandum of understanding
2. Informal interactions only
3. Both formal agreements and informal interactions
9. Don't know

IF MCR02 = 2 or 9, GO TO MCR04; ELSE CONTINUE TO MCR03.

MCR03 (Supplement C). Do your partnership agreements with physical health care providers include the following? ***Check all that apply.***

a. Resources or payments to providers
b. Training for EHS/HS staff
c. Physical health services are given to children and families at EHS/HS sites
d. Physical health services to EHS/HS children and families are given at other health sites/locations
e. Physical health services are provided for pregnant women
f. Joint planning

g. Consultation
h. Outreach
i. Membership on the HSAC
j. Other (specify)_____

MCR04 (Supplement C). Thinking about the physical health of the children and families you serve, please describe your relationship with each of the following types of service providers during the past 12 months. Please rate your relationship on a scale of 0 (no working relationship) to 3 (MOU/formalized collaboration or partnership) ***Select one response per row.***

ORGANIZATIONS	*RESPONSE CODES* 0. No working relationship 1. 2, 3. Formal MOU (memorandum of understanding)/formalized collaboration or partnership 4. Not applicable
a. General health care providers in private practice (e.g., MD, RN)	0 1 2 3 4
b. General health care providers from local/state health departments	0 1 2 3 4
c. General health care providers in Federally Qualified Health Centers	0 1 2 3 4
d. General health care providers in the Indian Health Service	0 1 2 3 4
e. General health care providers in a Tribally operated health facility	0 1 2 3 4
f. Specialist providers in private practice (e.g., asthma, diabetes)	0 1 2 3 4
g. Specialist providers from local/state health departments	0 1 2 3 4
h. Specialist providers in Federally Qualified Health Centers	0 1 2 3 4
i. Specialist health care providers in the Indian Health Service	0 1 2 3 4
j. Specialist health care providers in a Tribally operated health facility	0 1 2 3 4
k. Home-visiting providers	0 1 2 3 4
l. Nutritionists (e.g., registered dieticians)	0 1 2 3 4
m. Other (specify)_____	0 1 2 3 4

MCR05 (Supplement C). What are the major barriers you face when working with parents or guardians to obtain screening and treatment services for physical health? ***Check all that apply.***

a. Not getting parental/guardian consent (permission) for screening or treatment services
b. Cultural or religious beliefs or barriers (e.g., male staff should not speak to female caregivers)
c. Language barriers between HS staff and families
d. Literacy barriers (reading ability or health literacy level of parent or guardian is low)
e. Families move a lot/mailing addresses are not current
f. Families change their cell or telephone numbers a lot/phone numbers are not current

g. Parent/guardian does not have a telephone
h. Lack of transportation/distance to provider office
i. Lack of child care
j. Appointment times not available to fit parent/guardian schedule
k. Long wait times to get services once at provider's office
l. Parent/guardian lack of time
m. Parent/guardian does not understand importance of, does not want to talk about, or resists screening/treatment
n. Lack of available generalist providers (e.g., pediatricians, dentists)
o. Lack of specialist providers
p. Lack of culturally competent providers
q. Language barriers between families and providers
r. Insurance and out of pocket costs (e.g., no health insurance, Medicaid not accepted, out of pocket expenses too high)
s. Limited Medicaid transferability across state lines
t. Lack of staff time to follow-up
u. HS staff lack knowledge of resources
v. Other (specify) _____

MCR06. Overall, how would you describe the ability of your partnerships to handle the physical health needs of children in your program? ***Select one.***

1. Not Adequate
2. Somewhat Adequate
3. Adequate
4. Very Adequate
5. Not Applicable

MCR07. How would you describe the ability of your partnerships to handle the needs of children living with disabilities in your program? ***Select one.***

1. Not Adequate
2. Somewhat Adequate
3. Adequate
4. Very Adequate
5. Not Applicable

MCR08 (Supplement C). Thinking about the behavioral/mental health of the children and families you serve, please describe your relationship with each of the following types of service providers during the past 12 months. Please rate your relationship on a scale of 0 (no working relationship) to 3 (MOU/formalized collaboration or partnership). ***Select one for each row.***

ORGANIZATIONS	*RESPONSE CODES* 0. No working relationship 1. 2. 3. Formal MOU (memorandum of understanding)/formalized collaboration or partnership 4. Not applicable
a. State or local agency(ies) providing behavioral/mental health prevention and treatment services	0 1 2 3 4
b. Private, for profit behavioral/mental health providers	0 1 2 3 4

c. Behavioral/mental providers in hospitals	0 1 2 3 4
d. Behavioral/mental health providers in nonprofit agencies	0 1 2 3 4
e. Home-visiting providers	0 1 2 3 4
f. Behavioral/mental health providers in the Indian Health Service	0 1 2 3 4
g. Behavioral/mental health providers in a Tribally operated health facility	0 1 2 3 4
h. Other behavioral/mental health consultants (specify)_____	0 1 2 3 4

IF MCR08h = filled, GO TO MCR09; ELSE CONTINUE TO MCR10.

MCR09 (Supplement C). You mentioned that you use behavioral or mental health consultants. How do you use behavioral health consultants in your program? ***Check all that apply****.*

a. Behavioral health screenings on site
b. Participating in IEP meetings about individual child
c. Providing a behavioral health treatment or intervention for an individual child
d. Providing a behavioral health treatment or intervention in a group form
e. Working with families to conduct behavioral health education Helping families with referrals to other behavioral health providers
f. Educating EHS/HS staff about behavioral health issues

MCR10 (Supplement C). How are behavioral health services typically coordinated with other agencies or community partners? ***Select one***.

1. Formal agreements or memorandum of understanding
2. Informal interactions only
3. Both formal agreements and informal interactions
9. Don't know

IF MCR10 = 2 or 9, GO TO MCR12; ELSE CONTINUE TO MCR11.

MCR11 (Supplement C). Do your partnership agreements with behavioral or mental health care providers include the following? ***Check all that apply.***

a. Resources or payments to providers
b. Training for EHS/HS staff
c. Behavioral or mental health services given to children and families at EHS/HS sites
d. Behavioral or mental health services given to children and families at other health sites/locations
e. Behavioral or mental health services provided to pregnant women
f. Joint planning
g. Consultation
h. Outreach
i. Membership on the HSAC
j. Other (specify)_____

MCR12 (Supplement C). What are the major barriers you face when working with parents/guardians to obtain necessary screening and treatment services for behavioral health? ***Check all that apply.***

a. Not getting parental/guardian consent (permission) for screening or services

b. Cultural or religious beliefs or barriers (e.g., male staff should not speak to female caregivers)
c. Language barriers between HS staff and families
d. Literacy barriers (reading ability or health literacy level of parent or guardian is low)
e. Families move a lot/mailing addresses are not current
f. Families change their cell or telephone numbers a lot/phone numbers are not current
g. Parent/guardian does not have a telephone
h. Lack of transportation/distance to provider office
i. Lack of child care
j. Appointment times not available to fit parent/guardian schedule
k. Long wait times to get services once at provider's office
l. Parent/guardian lack of time
m. Parent/guardian does not understand importance of, does not want to talk about, or resists screening/treatment
n. Lack of available generalist providers (e.g., pediatricians, dentists)
o. Lack of specialist providers
p. Lack of culturally competent providers
q. Language barriers between families and providers
r. Insurance and out of pocket costs (e.g., no health insurance, Medicaid not accepted, out of pocket expenses too high)
s. Limited Medicaid transferability across state lines
t. Lack of staff time to follow-up
u. HS staff lack knowledge of resources
v. Other (specify) _____

MCR13. Overall, how would you describe the ability of your partnerships to handle the behavioral health needs of children in your program? ***Select one.***

1. Not Adequate
2. Somewhat Adequate
3. Adequate
4. Very Adequate
5. Not Applicable

MCR14 (Supplement D). Thinking about the oral health of the children and families you serve, please describe your relationship with each of the following types of service providers during the past 12 months. Please rate your relationship on a scale of 0 (no working relationship) to 3 (MOU/formalized collaboration or partnership). ***Select one for each row.***

ORGANIZATIONS	*RESPONSE CODES* 0. No working relationship 1. 2. 3. Formal MOU (memorandum of understanding)/formalized collaboration or partnership 4. Not applicable
a. Dentists in private practice	0 1 2 3 4
b. Dentists from local/state health departments	0 1 2 3 4
c. Dentists in Federally Qualified Health Centers (FQHC)	0 1 2 3 4
d. Dentists with the Indian Health Service	0 1 2 3 4

e.	Dentists in a Tribally operated dental facility	0 1 2 3 4
f.	Dental hygienists in private practice	0 1 2 3 4
g.	Dental hygienists from local/state health departments	0 1 2 3 4
h.	Dental hygienists in Federally Qualified Health Centers	0 1 2 3 4
i.	Dental hygienists with the Indian Health Service	0 1 2 3 4
j.	Dental hygienists in a tribally operated dental facility	0 1 2 3 4
k.	Portable/mobile dental practices	0 1 2 3 4
l.	Dental schools	0 1 2 3 4
m.	Dental hygiene schools or programs	0 1 2 3 4
n.	Physicians in private practice	0 1 2 3 4
o.	Physicians in public health clinics (e.g., from local/state health departments, FQHCs)	0 1 2 3 4
p.	Other (specify)_____	0 1 2 3 4

MCR15 (Supplement D). How are oral health services usually coordinated with other agencies or community partners? ***Select one***.

1. Formal agreements or memorandum of understanding
2. Informal interactions only
3. Both formal agreements and informal interactions
9. Don't know

IF MCR15 = 2 or 9, GO TO MCR17; ELSE CONTINUE TO MCR16.

MCR16 (Supplement D). Do your partnership agreements with oral health care providers include the following? ***Check all that apply.***

a. Resources or payments to providers
b. Training for EHS/HS staff
c. Oral health services provided to children (ages 4 and older) and families at EHS/HS sites
d. Oral health services provided to children (ages 4 and older) and families at other health sites/locations
e. Oral health services provided to young children ages 0–3 at EHS/HS sites
f. Oral health services provided to young children ages 0–3 at other health sites/locations
g. Oral health services provided to pregnant women
h. Joint planning
i. Consultation
j. Outreach
k. Other (specify)_____

MCR17 (Supplement D). What are the major barriers you face when working with parents/guardians to obtain necessary screening and treatment services for oral health? ***Check all that apply***.

a. Not getting parental/guardian consent (permission) for screening or services
b. Cultural or religious beliefs or barriers (e.g., male staff should not speak to female caregivers)
c. Language barriers between HS staff and families
d. Literacy barriers (reading ability or health literacy level of parent or guardian is low)

e. Families move a lot/mailing addresses are not current
f. Families change their cell or telephone numbers a lot/phone numbers are not current
g. Parent/guardian does not have a telephone
h. Lack of transportation/distance to provider office
i. Lack of child care
j. Appointment times not available to fit parent/guardian schedule
k. Long wait times to get services once at provider's office
l. Parent/guardian lack of time
m. Parent/guardian does not understand importance of, does not want to talk about, or resists screening/treatment
n. Lack of available generalist providers (e.g., pediatricians, dentists)
o. Lack of specialist providers
p. Lack of culturally competent providers
q. Language barriers between families and providers
r. Insurance and out of pocket costs (e.g., no health insurance, Medicaid not accepted, out of pocket expenses too high)
s. Limited Medicaid transferability across state lines
t. Lack of staff time to follow-up
u. HS staff lack knowledge of resources
v. Other (specify) _____

MCR18. Overall, how would you describe the ability of your partnerships to handle the oral health needs of children in your program? ***Select one.***

1. Not Adequate
2. Somewhat Adequate
3. Adequate
4. Very Adequate
5. Not Applicable

MCR19. What process(es) do you use to ensure that children receive follow-up services (for physical health, oral health, behavioral health)? ***Check all that apply.***

a. Conduct a periodic review of child health files to ensure that follow-up service were received
b. Follow up with health care providers to obtain copy of health service record
c. Follow up with parents/guardians to ensure that health services were received
d. Discuss with health staff at regular program meetings
e. Follow up with classroom teachers
f. Use an external evaluator to review health records
g. Other (specify_____)

MCR20. Is a set portion of your EHS/HS budget designated for treatment services for physical health, behavioral health and/or oral health? ***Select one***.

1. Yes
2. No
9. I don't know

IF MCR20 = No, GO TO MCR22; ELSE CONTINUE TO MCR21.

MCR21. What funds are used to pay for physical health, behavioral health and oral health treatment services? ***Check all that apply***.

a. Medicaid/SCHIP, SCHIP, other publicly funded insurance for children
b. County indigent funds
c. Private insurance
d. Family self-pay, out of pocket expense
e. Grant funding from an external source
f. In-kind contributions from providers
g. EHS/HS program budget
h. Other source (specify) _____
i. Other source (specify)_____

MCR22. Do you (or your staff) provide health services or health programs in the home? ***Select one.***

1. Yes
2. No
9. I don't know

IF MCR22 = No, GO TO MCR22; ELSE CONTINUE TO PRG01.

MCR23. What health service or health programs do you conduct in the home? ***Check all that apply***.

a. Conduct health screenings
b. Provide immunizations
c. Attend to the physical health needs of children with chronic health issues
d. Teach child about healthy behaviors (e.g., proper teeth brushing)
e. Teach parents/families about supporting healthy behaviors
f. Provide counseling or other mental health services
g. Provide nutritional services
h. Help families enroll in health insurance
i. Other (specify:_____)

MCR24. What barriers, if any, do you face when providing health services or programs in the home? ***Check all that apply***.

a. Cultural or religious beliefs or barriers (e.g., male staff should not speak to female caregivers)
b. Language barriers between HS staff and families
c. Literacy barriers (reading ability or health literacy level of parent or guardian is low)
d. Parent/guardian lack of time
e. Parent/guardian does not understand importance of screening/treatment
f. Parent/guardian resistance to treatment
g. No physical space to conduct activities in the home
h. Difficulty finding a quiet space to conduct activities without interruption
i. Privacy concerns to discuss health-related matters in the home
j. Discomfort of staff in being in the home
k. Safety issues for staff to be in the home
l. Other (specify:_____)

MODULE 4. PREVENTION AND PROMOTION ACTIVITIES

MODULE 4, SECTION 1. CURRENT HEALTH PROMOTION TOPIC SELECTION AND

The next sections include questions about the health promotion activities that your EHS/HS program conducts. Health promotion means any activity focusing on healthy behaviors and the prevention of disease (e.g., good oral hygiene, healthy eating).

PRG01 (Supplement D). For the following list of health topics and health promotion activities, please say whether you are addressing the topic with families in your EHS/HS program. ***Check all that apply***.

a. Injury prevention and safety (e.g., dog bites, motor vehicle safety/car accidents, food safety)
b. CPR or first aid
c. Alcohol or other drug use prevention or treatment
d. Tobacco use prevention or cessation
e. Environmental health (pesticide, lead, second hand smoke)
f. Nutrition and/or healthy eating practices
g. Physical activity and/or fitness
h. Behavioral or mental health
i. Violence prevention (e.g., bullying, fighting, partner violence)
j. Education on asthma triggers or prevention
k. Oral hygiene
l. Hand washing or hand hygiene
m. Importance of sleep or rest for children
n. Importance of immunizations
o. Sun safety and skin cancer prevention
p. Head lice
q. Bed bugs
r. Family planning
s. Prenatal health
t. Breastfeeding/lactation
u. Postpartum health and care (e.g., depression)
v. Caring for an infant (e.g., diapering, bathing)
w. Other (specify)_____

PRG02 (Supplement D). What factors/information contributed to you choosing these health topics as targets of health promotion? ***Check all that apply***.

a. Community or self-assessment data
b. Informal parent input
c. EHS/HS program priority areas (e.g., identified through health screens)
d. Observation of children
e. Observation of parents
f. Surveys with parents
g. Health Services Advisory Committee recommendations
h. EHS/HS Director recommendation
i. Community partner organization recommendation
j. Local/state policy (e.g., health insurance, health impact assessment, zoning, economic)
k. Office of Head Start (national) priorities
l. Other (specify)_____

PRG03. When there is a health topic that you feel needs to be addressed, how do you find possible resources or curriculum? ***Check all that apply***.

a. Prior use/familiarity with the curriculum

b. Recommendation of other EHS/HS programs
c. Recommendation from HSAC
d. Recommendation from consulting provider or other community partners
e. Head Start web site (ECLKC)
f. Technical assistance network for EHS/HS (e.g., Head Start National Center on Health)
g. Child care health and safety resources (e.g., Caring for our children, child care health consultant)
h. Professional association websites or listservs (e.g., AAP, APA, AAPD)
i. Recommendation from state or local government (e.g., state dental director)
j. General internet search
k. Other (specify)_____

PRG04 (Supplement D)**.** We are interested in getting a better understanding of the type of programs or curricula you use to address health topics and health promotion activities. For example, you may use *I Am Moving, I Am Learning* to address overweight and obesity or *Bright Smiles* to address oral health needs. Please fill out the table below, listing the health topic or health promotion area being addressed, the name of the curricula, whether the curricula is "off the shelf," adapted, or created by your program staff, and how long you have been using it. Please also note who is receiving the program or curricula (e.g., children, parents, staff).

Health Promotion Topic	Target population (children, parents, staff) ***List all that apply***.	Name of curriculum (list DK or "no name" if applicable)	"off the shelf" (as is), adapted from an existing program, or newly created for your purposes?	Length of time using the program in your EHS/HS
1.				
2.				
3.				
4.				
5.				

IF PRG04 DOES NOT LIST I Am Moving, I Am Learning (or IMIL, IM/IL, etc.) THEN GO TO PRG04a; ELSE CONTINUE TO PRG05.

PRG04a (Supplement D). You did not list *I Am Moving, I Am Learning (IMIL)* as a program that you are using. What are the reasons you are not currently using IMIL? ***Check all that apply.***

a. I have never heard of the program
b. The training that was provided was not sufficient for implementation, more training is needed
c. Guides for how to train staff are needed
d. Staff have not been trained in the curriculum
e. Not enough time to implement it
f. Not enough resources to implement it
g. Children or parents do not like it
h. Staff do not like it
i. Program administrators are currently not interested in using it
j. We are unable to adapt it to meet the language and cultural needs of our children and families
k. We found another obesity prevention curriculum that we like better
l. We used IMIL in the past, but are not using it now

m. We are not using IMIL now, but plan to do so in the next year
n. We have no plans for using IMIL right now
o. Other (specify) _____

PRG05 (Supplement D). To what extent are health materials selected or adapted to match the cultures and languages of families you serve? ***Select one.***

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

PRG06 (Supplement D). What method(s) do you use most often to share health promotion information with the families that you serve? ***Check all that apply***.

a. Written materials (e.g., newsletters)
b. A one-time, in-person session
c. Multiple in-person training sessions
d. Parent to parent
e. Phone based sessions
f. Electronically (e.g., email, web based information)
g. Other (specify) _____

PRG07 (Supplement D). What funds are used for prevention and health promotion activities? ***Check all that apply***.

a. Medicaid/SCHIP, SCHIP, other publicly funded insurance for children
b. County indigent funds
c. Private insurance
d. Family self-pay, out of pocket expense
e. Grant funding from an external source
f. In-kind contributions from providers
g. EHS/HS program budget
h. Other source (specify) _____
i. Other source (specify)_____

MODULE 4, SECTION 2. IMPLEMENTATION ISSUES

Now please think about what makes it easy or hard to get health promotion activities started in your center.

IMP01. What are the biggest challenges to starting health promotion activities in your EHS/HS program? ***Check all that apply***.

a. Lack of support from HSAC
b. Lack of support from the director
c. Lack of staff buy-in
d. Not enough time to provide training of staff
e. Lack of parent or family interest/support in the topic
f. Limited time to implement
g. Lack of parent or family time to engage in the activity or the timing of the activity
h. Poor quality of the health promotion curriculum or program to address the health topic
i. Poor quality of the health promotion trainers

j. Not having enough staff who speak the language(s) of the families we serve
k. Not having enough staff who come from the cultural background(s) of the families we serve
l. Not having enough health materials (e.g., written materials, curricula) in the language(s) of the families we serve
m. Not having enough health materials (e.g., written materials, curricula) that are culturally appropriate for all families
n. Limited parent literacy
o. Competing program priorities/not enough resources or funds
p. Other (specify)_____

IMP02 (Supplement D). Does your program do any of the following to encourage parents/guardians to take part in health-related activities or events? Do you: ***Check all that apply.***

a. Offer incentives such as door prizes or samples of products?
b. Provide transportation
c. Provide child care
d. Provide interpreters
e. Serve food such as snacks or dinner/supper
f. Other (specify)_____

IMP03 (Supplement D). Does your program regularly monitor the health promotion activities (e.g., education, curricula) offered to **children**? ***Select one.***

1. Yes
2. No

IMP04 (Supplement D). Does your program regularly monitor the health promotion activities (e.g., education, curricula) offered to **families**? ***Select one.***

1. Yes
2. No

IF IMP04 = No, GO TO PRO01; ELSE CONTINUE TO IMP05.

IMP05 (Supplement D). What types of information do you use to keep track of how your health promotion activities are going? ***Check all that apply.***

a. Tracking data on number and type of health promotion activities
b. Surveys with children about their response to the activity, change in health knowledge
c. Surveys with parents/families about their response to the activity, change in health knowledge or behavior
d. Surveys with staff about activity roll out, impact on children
e. Home visitor information about how families are using the health promotion activity/information
f. Classroom/home visit monitoring of activities
g. Physical measurements (e.g., height, weight, BMI)
h. Other (specify).____

MODULE 4, SECTION 3. OTHER FAMILY HEALTH PROMOTION ACTIVITIES

PRO01. Do you offer any of the following **services** to families? ***Select one response for each row.***

SERVICES	*RESPONSE CODES* 1. Yes 2. No 9. Don't know
a. Health related events for the entire family including health services for other family members	1 2 9
b. Weight management program or education	1 2 9
c. Smoking cessation	1 2 9
d. Information about health insurance and assistance enrolling	1 2 9
e. Workshops or education on parenting (e.g., classes on child development, education in being a parent, understanding children with special needs)	1 2 9
f. Adult literacy or health program (including Adult Basic Education)	1 2 9
g. Health literacy	1 2 9
h. Health or social services offered collaboratively by service agencies such as hospitals	1 2 9
i. Other (specify)_____	1 2 9

PRO02. Even if your program does not include EHS, does your program offer any services to pregnant women?

1. Yes
2. No
9. Don't know

IF PRO02 = No or Don't know, GO TO PRO04; ELSE CONTINUE TO PRO03.

PRO03. Which of the following services do you offer to pregnant women? ***Select one response for each row.***

SERVICES	*RESPONSE CODES* 1. Yes 2. No 9. Don't know
a. A referral to a OB, nurse/midwife, or other provider for pregnant women	1 2 9
b. A referral to a dentist for the mother	1 2 9
c. A referral to a pregnancy or child birth class	1 2 9
d. A referral for a doula (or someone to help with the birthing process)	1 2 9
e. Information on how to take care of themselves during pregnancy	1 2 9
f. The chance to get together with other pregnant women or mothers	1 2 9

g. Nutrition information	1 2 9
h. Classes for new or expectant fathers	1 2 9
i. Information on how to prepare their home for a new baby	1 2 9
j. Help finding clothes, a stroller, or other baby care items	1 2 9
k. Information on how to take care of babies	1 2 9
l. Information on breastfeeding	1 2 9
m. A referral to someone to help with breastfeeding (lactation consultant)	1 2 9
n. A referral for smoking cessation	1 2 9
o. Referrals for drug and alcohol cessation	1 2 9
p. Postpartum services, including information on postpartum depression	1 2 9
q. A referral to a pediatrician for the baby	1 2 9
r. Information on how children grow and develop	1 2 9
s. Parenting classes	1 2 9
t. Sibling classes	1 2 9
u. Other (specify)_____	1 2 9

PRO04 (Supplement D). What funds are used to pay for family health promotion activities? ***Check all that apply***.

a. Medicaid/SCHIP, SCHIP, other publicly funded insurance for children
b. County indigent funds
c. Private insurance
d. Family self-pay, out of pocket expense
e. Grant funding from an external source
f. In-kind contributions from providers
g. EHS/HS program budget
h. Other source (specify) _____
i. Other source (specify)_____
j. Not applicable, we do not offer family health promotion activities

MODULE 5. STAFF WELLNESS

The next few questions ask about activities related to staff health and well-being.

SWL01 (Supplement B). Within the past year, has your program offered staff members the following . . . ? ***Select one response per row.***

WELLNESS ACTIVITIES	*RESPONSE CODES* 1. Yes 2. No
a. Physical health screenings	1 2
b. Oral health screenings	1 2
c. Asthma management	1 2
d. Weight management, nutrition information	1 2
e. Physical activity/fitness	1 2
f. Tobacco cessation	1 2

g. Stress management	1 2
h. Injury prevention/safety	1 2
i. Cancer screening	1 2

SWL02 (Supplement B). How often do staff members participate in emergency preparedness education sessions or trainings? ***Select one***.

1. Never, staff members do not regularly participate in such trainings
2. Once a year
3. Twice a year
4. Every two to five months
5. Every month
6. Other (specify)_____

SWL03 (Supplement B). What funds are used to pay for staff well-being activities? ***Check all that apply***.

a. Medicaid
b. County indigent funds
c. Private insurance
d. Self-pay, out of pocket expense
e. Grant funding from an external source
f. In-kind contributions from providers
g. EHS/HS program budget
h. Other source (specify) _____
i. Other source (specify)_____
j. Not applicable, we do not offer staff well-being activities

MODULE 6. BROADER COMMUNITY LINKAGES

This section asks about the broader community service network that supports your EHS/HS health programming.

PRT01 (Supplement A). With which agencies and organizations do you normally work to address or support the health needs of the children and families in your EHS/HS program? ***Check all that apply.***

a. Social service agency (e.g., TANF)
b. Food/nutrition agency (e.g., WIC)
c. Home visiting programs external to your EHS/HS program
d. Local health departments, department of public health
e. Migrant community health centers
f. Indian Health Services (IHS)
g. Tribal organizations
h. Safety net dental clinics (e.g., FQHCs, community dental clinics, county health department clinics)
i. Community health centers and/or local hospitals
j. Community behavioral or mental health center
k. Migrant education
l. College or university
m. Religious organizations
n. Public schools/Local Educational Agency (LEA)
o. Part C and Part B Individuals with Disabilities Education Act (IDEA) partners

p. Programs to provide family financial planning
q. Job service agency
r. Legal aid
s. Other community based organization (specify)_____

PRT02. In your EHS/HS program, which of the following health needs are **NOT** being met (or being met well) by the agencies and organizations you work with? ***Check all that apply.***

a. Health care
b. Oral health care
c. Behavioral health care
d. Services for children with disabilities/medically fragile children
e. Asthma management and/or education programs
f. Services for weight control
g. Hearing or vision services
h. Treatment for alcohol or substance use
i. Programs for smoking cessation
j. Services for pregnant women (e.g., prenatal care, postpartum care)
k. Environmental health concerns
l. Injury prevention or safety concerns, emergency management
m. Some other health service (specify) _____

PRT03 (Supplement A). What types of health-related services or knowledge do your community partners provide (e.g., help with referrals, treatment services, health education)? Please include those that are paid for by your program as well as unpaid (in-kind) donations. ***Check all responses that apply for each row.***

DISPLAY AGENCIES AND ORGANIZATIONS SELECTED IN PRT01.

RESPONSE CODES
1. Health services, paid
2. Health services, unpaid/in-kind
3. Health education, paid
4. Health education, unpaid/in-kind
5. Providing referral support/linking families, paid
6. Providing referral support/linking families, unpaid/in-kind
7. Other support, paid
8. Other support, unpaid/in-kind

PRT04. What types of health-related community partners do you NOT have a relationship with now, but you would **LIKE TO** have a relationship with? ***Check all that apply.***

a. Social service agency (e.g., TANF)
b. Food/nutrition agency (e.g., WIC)
c. Home visiting programs
d. Local health departments, department of public health
e. Migrant community health centers
f. Indian health services
g. Tribal organizations
h. Safety net dental clinics (e.g., FQHCs, community dental clinics, county health department clinics)
i. Community health centers and/or local hospitals
j. Community behavioral or mental health center

k. Migrant education
l. College or university
m. Religious organization
n. Public schools/LEA
o. Part C and Part B Individuals with Disabilities Education Act (IDEA) partners
p. Programs to provide family financial planning
q. Job service agency
r. Legal aid
s. Other community based organization (Specify:_____)

PRT05 (Supplement A). In the past 12 months, how much did the following things make it difficult to provide health services or programs to your EHS/HS children and families***. Select one response per row.***

BARRIERS	*RESPONSE CODES* 1. Made it not at all difficult 2. Made it somewhat difficult 3. Made it extremely difficult
a. Establishing linkages/partnerships with health providers for offering health services (e.g., clinical services)	1 2 3
b. Establishing linkages/partnerships with health organizations for providing prevention or health promotion programs	1 2 3
c. Establishing linkages/partnerships with private resources (e.g., faith-based, foundations, business) regarding prevention or health promotion programs	1 2 3
d. Sharing health data/information on children/families served jointly by EHS/HS and other agencies	1 2 3
e. Obtaining timely evaluations of children with disabilities	1 2 3
f. Having enough resources to serve health needs of children who do not qualify for Part B and C assistance	1 2 3
g. Having staff attend IEF (income eligibility form) or IFSP (individual family service plan) meetings	1 2 3
h. Other reason (specify) _____	

PRT06 (Supplement A). What percentage of your community partners are culturally responsive to the needs of your ethnic and linguistic minority families? ***Select one.***

1. 0–25%
2. 26–50%
3. 51–75%
4. 76–100%
9. Don't know

MODULE 7. HEALTH MANAGER BACKGROUND

These next questions ask about your background including educational background and work experience.

EDU01. What is the highest grade or year of school that you completed. ***Select one***.

1. Less than a high school diploma/equivalent (GED)
2. High school diploma/equivalent (GED)
3. Vocational/technical program after high school but no vocational/technical diploma
4. Vocational/technical diploma after high school
5. Some college but no degree
6. Associate degree
7. Bachelor's degree
8. Graduate or professional school but no degree
9. Master's degree (MA, MS, MPH, MSN, MBA)
10. Doctorate degree (Ph.D., Ed.D.)
11. Other Postgraduate Degree (Medicine/MD; Dentistry/DDS; Law/JD/LLb; Etc.)

EDU02. Please describe how much coursework you had in the following areas? ***Select one response per row.***

AREA	*RESPONSE CODES* 1. I have not completed any course work in this area 2. I completed a few courses 3. I received an AA or completed a certificate program in this area 4. I received a BA in this area (e.g., major, minor, concentration) 5 I received my master's, doctorate or other postgraduate degree in this area
a. Child health and development	1 2 3 4 5
b. Children with special health care needs/disability	1 2 3 4 5
c. Medicine	1 2 3 4 5
d. Nursing	1 2 3 4 5
e. Behavioral or mental health (e.g., counseling, family therapy)	1 2 3 4 5
f. Social work	1 2 3 4 5
g. Health education	1 2 3 4 5
h. Nutrition	1 2 3 4 5
i. Physical fitness/physical education	1 2 3 4 5
j. Public health/community health	1 2 3 4 5
k. Other health topic (specify_____)	1 2 3 4 5

EDU03. Have you ever had any licenses, certificates or credentials relating to health such as medicine, nursing, or oral health (include those earned outside of the United States)? ***Select one***.

1. Yes
2. No

IF EDU03 = No GO TO EDU05; ELSE CONTINUE TO EDU04.

EDU04. For each one that you have had, say whether it is active at this time. ***Select one response per row*.**

LICENSE/CERTIFICATION	*RESPONSE CODES* 1. Yes, it is active at this time 2. No, I had one but it is not active now 3. Not applicable
a. A license as a physician (MD)	1 2 3
b. A license as an osteopath (DO)	1 2 3
c. A license as a registered nurse (RN)	1 2 3
d. A license as a licensed practical nurse (LPN)	1 2 3
e. A licensed vocational nurse	1 2 3
f. A certification as a nurse practitioner (NP)	1 2 3
g. A certification as a school nurse	1 2 3
h. A certification or license as a social worker	1 2 3
i. A certification or license as a counselor	1 2 3
j. A certification or license as a psychologist	1 2 3
k. A license as a psychiatrist	1 2 3
l. A license as a dentist	1 2 3
m. A certification or license as a dental hygienist	1 2 3
n. A certification or license as a nutritionist	1 2 3
o. Other license, certificate or credential (Please specify) _____	1 2 3

EDU05 (Supplement B). Have you completed training to become a Child Care Health Consultant (CCHC)? ***Select one.***

1. Yes
2. I have started training, but have not yet completed it
3. No

EDU06 (Supplement B)**.** Counting this program year, how many years have you ever worked … Note: you may have the same answer for more than one row. ***Select one response per row.***

WORK HISTORY	*RESPONSE CODES* 1. No experience of this type 2. Less than 1 year 3. 1–2 years 4. 3–5 years 5. 6–10 years 6. 11–24 years 7. 25 years or more
a. With children under 6 years of age in any child care or education setting? (Include years as child care provider, teacher, director, etc., for EHS/HS and non-Head Start settings, but do not include years spent raising your own children.)	1 2 3 4 5 6 7
b. In any EHS/HS programs? (Include MSHS and AIAN)	1 2 3 4 5 6 7
c. In any Migrant and Seasonal (MSHS) EHS/HS programs, specifically?	1 2 3 4 5 6 7

d.	In any American Indian or Alaska Native (AIAN) EHS/HS programs, specifically?	1 2 3 4 5 6 7
e.	As a health manager in an EHS/HS program?	1 2 3 4 5 6 7
f.	In a health care setting, such as a community health clinic or school-based health center?	1 2 3 4 5 6 7

EDU07. Before the position you have now, what other positions have you held at your current program or another EHS/HS program? ***Check all that apply***.

a. Health manager or health coordinator at another EHS/HS program
b. Teacher
c. Teacher's aide/instructional aide
d. Family service worker/home visitor
e. Parent involvement coordinator/family service coordinator
f. Outreach staff/recruiter/enrollment coordinator
g. Health aide
h. Counselor
i. Disability coordinator
j. Behavioral health (or mental health) coordinator
k. Nutrition coordinator
l. Culinary or food services staff
m. Receptionist/office staff
n. Bus driver or related transportation
o. Center director, associate center director, or other program manager
p. Other (Specify) _____
q. None—no previous positions

DEM01. What is your sex? ***Select one***.

1. Male
2. Female

DEM02. Are you Hispanic, Latino/a, or Spanish origin? ***One or more categories may be selected.***

a. No, not of Hispanic, Latino/a, or Spanish origin
b. Yes, Mexican, Mexican American, Chicano/a
c. Yes, Puerto Rican
d. Yes, Cuban
e. Yes, another Hispanic, Latino, or Spanish origin

DEM03. What is your race? ***One or more categories may be selected.***

a. White
b. Black or African American
c. American Indian or Alaska Native
d. Asian Indian
e. Chinese
f. Filipino
g. Japanese
h. Korean
i. Vietnamese
j. Other Asian

k. Native Hawaiian
l. Guamanian or Chamorro
m. Samoan
n. Other Pacific Islander

DEM04. How well do you speak English? ***Select one.***

1. Very well
2. Well
3. Not well
4. Not at all

DEM05. Do you speak a language other than English at home? ***Select one.***

1. Yes, please specify other language: _____
2. No

DEM07. Is your age . . .? ***Select one.***

1. Under age 25
2. 25 to 34
3. 35 to 44
4. 45 to 54
5. 55 to 64
6. 65 or older

DEM08. About how much do you make each year at EHS/HS? ***Select one***.

1. Less than $10,000
2. 10,000–20,000
3. 20,001–30,000
4. 30,001–40,000
5. 40,001–50,000
6. 50,001–60,000
7. 60,001–70,000
8. 70,001–80,000
9. 80,001–90,000
10. More than 90,001

DEM09. Do you or did you ever have a child in your household who attends/attended EHS/HS? ***Select one***.

1. Yes
2. No

DEM10. How satisfied are you with your current position as a health manager? ***Select one***.

1. Not at all satisfied (very dissatisfied)
2. Dissatisfied
3. Neutral (neither satisfied nor dissatisfied)
4. Satisfied
5. Very satisfied

DEM11. Is there anything that you would like to share, either positive or negative, about your experience with the health services area of your program and/or the health needs of children and families in your program?

_____ *(OPEN ENDED)*

In addition to the on-line survey that you have just completed for the Head Start Health Managers Descriptive Study, we will also be conducting Interviews with a small number of health managers, teachers, family service workers, and home visitors. Thus, we may want to contact you in the future to invite you to participate in the interview portion of the study or to nominate other members of your program's staff to participate in the study. If your program is selected for this phase of the study, you or your colleagues would have the opportunity at that time to decide if you would like to participate.

FUP01. We reached you at [email address]. Is this the best email address to reach you? If no, please enter your preferred email address. ***Select one.***

1. Yes
2. No → [*enter best email address*]

FUP02. Is there a phone number we can use to get in touch with you? If yes, please enter the phone number starting with the area code. ***Select one***.

1. Yes → [*enter best phone number*]
2. No

FUP03. What is the best time of day for our study staff member to call you? ***Check all that apply.***

a. 8 to 10 am
b. 10 to 12 pm
c. 12 to 2 pm
d. 2 to 4 pm
e. 4 to 6 pm

FUP04. Is there anything else we should know about the best time or method to reach you? **Open ended.**

Display on screen: Thank you for completing this survey. We know you are very busy and we appreciate the time and thought you put into your responses. As a reminder, you may want to print a copy of your responses for your records as you will not be able to access your survey once it has been submitted. Thank you again for your help with this study.

Appendix E. Semistructured Interview Protocols

This appendix includes the protocol for the semistructured interviews with health managers, as well as the protocol for the interviews with other staff (teachers, family service workers, and home visitors). See Chapter Two and Appendix C for additional details on the semistructured interviews. The interview protocols are annotated to show headers for each module.

OMB number: 0970-0415
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Head Start Heath Manager Descriptive Study
Head Start Heath Manager Semistructured Interview Protocol

EXPLANATION AND CONSENT FOR SEMI-STRUCTURED INTERVIEW

The Office of Head Start, Administration for Children and Families (ACF) within the Department of Health and Human Services (DHHS), is funding a Head Start Health Managers Descriptive Study. This study is being conducted by the RAND Corporation. The purpose of the study is to provide a current snapshot of health-related activities and programming within Early Head Start (EHS) and Head Start (HS) programs, to better understand the context in which the health services area operates, and to identify the current needs of health managers and health staff as they work towards improving the health of HS children, parents and staff. The objectives of the survey are to:

- Describe the characteristics of health managers and related staff in HS and EHS programs;
- Identify the current landscape of health services being offered to children and families;
- Determine how health initiatives are prioritized, implemented, and sustained; and
- Identify the programmatic features and policy levers that exist to support health services including staffing, environment, and community collaboration.

This study is descriptive; it is not designed to capture individual child or family data or performance standards compliance. Data from this study will not be used for monitoring purposes. Instead this study will provide the Office of Head Start with a picture of what Head Start programs are working on and the areas in which further assistance may be needed.

As part of this study, we asked all health managers within EHS/HS programs to complete an on-line survey. We are also conducting interviews with a small number of health managers, family service workers, teachers and home visitors to gain a better, more in-depth understanding of the health services area within HS. This phone interview will take about 45 minutes.

The risk to participation in this study is minimal. In any written reports of the data obtained from this survey, your responses will be combined with others and reported together. If quotations are used in any reports, they will not be connected to an individual or grantee. Identifiable information that you provide (e.g., name, program) will not be shared with anyone outside of the RAND project staff without your permission, except as required by law. At the end of the study, we will destroy any information that identifies you as a participant. There may be questions for which you do not have answers, but as stated earlier, we will not identify your name in any report.

Although there are no immediate benefits to you for answering the following questions, results from this study are expected to yield benefits to you in the future in your role as health

manager. Your participation in this study will provide important information that will help Head Start improve the health services area and the support, training, and technical assistance that you receive to enhance your health programming.

Taking part in this survey is voluntary and you may choose to skip any questions that you do not want to answer. While your participation is voluntary, we do hope you will decide to contribute to this important study. Your participation is extremely important to ensure that we capture what is occurring in Head Start programs.

If you have any questions or comments about the study please contact Lynn Karoly (Lynn_Karoly@rand.org, 703-413-1100 x 5359) or Laurie Martin (Laurie_Martin@rand.org, 703-413-1100 x 5083). If you have any questions about your rights as a research participant, you may contact Tora Bikson, Administrator, RAND Human Subjects Protection Committee by phone at (310) 393-0411 or by email: Tora_Bikson@rand.org.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0970-0415. The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

Do you agree to participate in this study?

Yes → proceed to survey

No → Thank you for your consideration

A. CONTACT INFORMATION

Interviewer: Before we begin, it would be helpful to obtain some information on your background and role in the Head Start program.

CON1: Name _____

CON2: Title _____

CON3: Head Start Program Name _____

CON4: Contact Phone Number _____

CON5: Contact Email _____

CON6: Interviewer Name _____

CON7: Interview Date and Time _____

B. PLANNING AND IMPLEMENTING HEALTH ACTIVITIES

Interviewer: To start, we would like to walk through some of the steps you take to decide on, plan for, and implement health promotion activities in your Head Start program. You reported on some of this in the survey, but we would like to learn more about some of the strategies that work for you and what makes this process difficult. Again, for these questions we are talking

about health promotion activities (anything that focuses on promoting healthy behaviors, and reducing the risk of disease or illness).

PIH1. Where do you go for information and/or technical assistance to support the health activities you conduct in your EHS/HS program? Please describe the sources of information you look for.

PIH2. How do you decide or prioritize which health promotion activities to conduct in the program? Walk me through this process.

Probe (if not covered):

- *Burden of health issues in your program, community or self-assessment data*
- *Feedback from HSAC*
- *Feedback from parents*
- *Requirements by Head Start, local or state policy mandates*

PIH3. What factors make the process of deciding which health promotion activities to conduct easier? What factors make the process of deciding which activities to conduct more challenging?

PIH4. How do you find out about and chose what materials, curricula or program(s) you are going to use to address the health issues or health promotion activities you have selected?

Probe:

- *Recommendations from OHS*
- *Recommendations from other health managers, professional groups, websites*
- *Evidence base*
- *Logistics—resources required to implement, cost*

PIH5. When you implement health promotion activities, how do you roll-out the activity? What has worked well in this process? What impedes roll-out? Implementation?

Probe:

- *Staff, administrative buy-in*
- *Sustainability- policy change, monitoring/evaluation*
- *Training—intensity, duration, frequency*
- *Child receptivity*

C. HEALTH SERVICES ADVISORY COMMITTEE

Interviewer: Next, we'd like to learn a bit more about the role and management of the Health Services Advisory Committee (HSAC).

HSC1 *[If HSHM survey indicates that the program shares an HSAC with another program.]* What do you see as some of the benefits of sharing an HSAC with another program? What are some of the challenges?

HSC2. How do you establish and maintain a Health Services Advisory Committee that includes professionals and other volunteers from the community? What facilitates this process? What factors make this process challenging?

HSC3. In the survey you reported that your HSAC did the following activities very well (you rated them as strongly agree) [FILL IN FROM SURVEY]. It would be helpful to understand how you have achieved this so we might draw from examples where the HSAC is working well to achieve this objective. Could you select 2–3 of these activities and talk about how you achieved them?

[Potential response items from survey]:

a. Develops comprehensive health promotion programs for HS children, families, and staff
b. Helps to develop health policies and procedures that support the health goals for HS children, families, and staff
c. Engages parents in identifying and accessing sources of continuous, accessible health care
d. Supports parents in becoming advocates for their children's health
e. Supports parents as leaders in efforts to improve the health of their community
f. Informs your program about current and emergent health issues, trends, and best practices
g. Develops long- and short-term goals and objectives and strategies for implementing services that meet the needs of the community
h. Advocates for community systems changes that support the health of the children and families in your program
i. Helps to establish ongoing, collaborative partnerships with community organizations
j. Educates health care providers, other professionals, and community leaders or policy makers on the needs and issues of HS/EHS/MS/AIAN children and families
k. Other (specify)_____

HSC4. Sometimes there is a real or perceived power differential between parents and professional service providers (e.g., physicians) on the Health Services Advisory Committee. What steps do you take to ensure that parents have a voice at the table? Feel comfortable participating?

D. SERVING THE MEDICALLY FRAGILE/CHRONIC CONDITION POPULATION

Interviewer: Now we'd like to ask a couple of questions about meeting the needs of medically fragile children and/or those with chronic health conditions.

MFP1. How do you serve children with multiple health needs? Is programming adapted in any way? If so, how?

MFP2. What challenges do you face in serving the children who are medically fragile, have chronic health issues, etc.? What happens for children that have a chronic health issue but do not meet the requirements for Part B/C?

MFP3. What supports (e.g., resources, training, staff, community partners) do you need that you don't have to support medically fragile children/children with chronic health conditions? Probe: Other challenges?

MFP4. What successes have you had in meeting the needs of children with multiple health needs? How did you arrive at this success? Describe.

E. HOME VISITING

HMV1. Do you work with home visitors in your program? If so, how do you train home visitors and work with them to implement health activities in the home? How do you monitor their activities?

HMV2. What about health case management services? To what extent does your program provide case management? Who provides case management services within your program? What is their case load?

HMV3. Does your program link with an external case manager through health services that you offer to some children and families (e.g., medically fragile)? What level of communication do you have with children's medical homes? What level of data sharing do you have?

F. PARTNERSHIPS WITH COMMUNITY PROVIDES AND OTHER STAKEHOLDERS

Interviewer: Next, we'd like to learn a bit more about how you engage with community health providers and the extent to which you engage in the broader network of community services to support your Head Start families.

PRT1. How do you go about identifying and engaging health providers to support health services in your program? To support health promotion activities in your program? What has facilitated that process? What has made it difficult to engage health providers? What is the level of effort to engage and sustain these partnerships?

PRT2. Do you link with community health activities to support the health activities within Head Start (e.g., health fairs)? If so, how did that linkage come about (e.g., HSAC, you or staff participate in other community coalitions or boards)? If not, why not?

PRT3. How would you characterize your partnerships with community organizations to support Head Start health activities? Do you feel that your Head Start program is well-integrated into the community service network?

PRT4. Are there particular partnerships that you would like to have, and have not been able to forge? If so, what are they, and what has impeded that partnership to date?

PRT5. What do you consider a medical home? Which definition do you use for a medical home? Where did you get that definition?

PRT6. How do you work with children's medical homes?

G. MONITORING AND EVALUATION

Interviewer: In the survey, we asked about how you track the implementation and impact of your health activities. We'd like to learn more about that process.

MEV1. How do you know whether you are meeting your objectives [regarding] health in your Head Start program? How do you track your progress or areas where you may be struggling? If so, what do you do with this information? (e.g., reach out to other HS programs). *Probe for evaluation information in these areas:*

- *Health screening,*
- *Referral for health services and following up on the referral,*
- *Prevention activities,*
- *Health education,*
- *Treating or addressing the needs of medically fragile children/children with chronic health conditions)*
- *What do you do if parents do not follow-up with services?*

MEV2. Do you evaluate/monitor your health activities? If so, how (classroom observation, monitoring changes in BMI, eating practices, etc.)? If not, why not?

Have any policies been created (e.g., policy on how much physical activity occurs) to facilitate implementation/sustainability of these evaluation processes? What are these policies?

MEV3. What recommendations/strategies would you suggest to better assist you in tracking and evaluating the health activities that you implement?

H. TRAINING/SUPPORT FOR HEALTH STAFF AND HEALTH ACTIVITIES

Interviewer: Finally, we would like to learn more about what would help you (and your health staff) in your efforts to support health in your Head Start program.

TSP1. What training topics would benefit you and/or your health staff in support health activities in your program? What topics would benefit other Head Start staff (e.g., teachers)?

TSP2. How do you provide training on health topics? Explore duration, frequency, intensity, and topics.

TSP3. What other resources or support would help you in these areas:

- Addressing the needs of chronically ill children?
- Supporting health promotion activities in your program?
- Linking with community partners to support HS health activities?
- Evaluating your health efforts?
- Other?

TSP4. Is there anything else that you would like to share about your experience as a health manager? The health needs of the children and families? The health needs of staff/teachers?

I. CONTACT INFORMATION FOR PROGRAM STAFF

Interviewer: In addition to the online survey of health managers and the interview you have just completed, we will also be conducting interviews with a small number of teachers, family service workers, and home visitors. At this time, we would like to ask you to nominate other members of your program's staff in these positions to participate in the study. If individuals on your program's staff are selected for interview, they will have the opportunity to decide if they would like to participate. The information you provide will allow us to contact them to see if they would like to be included in the study.

Please nominate up to two teachers, two family service workers, and two home visitors and provide their contact information (phone and email). If your program operates different models (e.g., Early Head Start, Head Start, Migrant and Seasonal program, American Indian or Alaska

Native program, home-based model), please nominate individuals for each position from different models.

POSITION (CIRCLE): TEACHER FSW HV	MODEL (CIRCLE): HS EHS MS AIAN	CENTER HOME
NAME	EMAIL	PHONE

POSITION (CIRCLE): TEACHER FSW HV	MODEL (CIRCLE): HS EHS MS AIAN	CENTER HOME
NAME	EMAIL	PHONE

POSITION (CIRCLE): TEACHER FSW HV	MODEL (CIRCLE): HS EHS MS AIAN	CENTER HOME
NAME	EMAIL	PHONE

POSITION (CIRCLE): TEACHER FSW HV	MODEL (CIRCLE): HS EHS MS AIAN	CENTER HOME
NAME	EMAIL	PHONE

POSITION (CIRCLE): TEACHER FSW HV	MODEL (CIRCLE): HS EHS MS AIAN	CENTER HOME
NAME	EMAIL	PHONE

POSITION (CIRCLE): TEACHER FSW HV	MODEL (CIRCLE): HS EHS MS AIAN	CENTER HOME
NAME	EMAIL	PHONE

POSITION (CIRCLE): TEACHER FSW HV	MODEL (CIRCLE): HS EHS MS AIAN	CENTER HOME
NAME	EMAIL	PHONE

POSITION (CIRCLE): TEACHER FSW HV	MODEL (CIRCLE): HS EHS MS AIAN	CENTER HOME
NAME	EMAIL	PHONE

[add more pages as needed]

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Head Start Heath Manager Descriptive Study
Head Start Teacher, Family Service Worker, and Home Visitor Semistructured Interview Protocol

EXPLANATION AND CONSENT FOR SEMI-STRUCTURED INTERVIEW

The Office of Head Start, Administration for Children and Families (ACF) within the Department of Health and Human Services (DHHS), is funding a Head Start Health Managers Descriptive Study. This study is being conducted by the RAND Corporation. The purpose of the study is to provide a current snapshot of health-related activities and programming within Early Head Start (EHS) and Head Start (HS) programs, to better understand the context in which the health services area operates, and to identify the current needs of health managers and health staff as they work towards improving the health of HS children, parents and staff. The objectives of the survey are to:

- Describe the characteristics of health managers and related staff in HS and EHS programs;
- Identify the current landscape of health services being offered to children and families;
- Determine how health initiatives are prioritized, implemented, and sustained; and
- Identify the programmatic features and policy levers that exist to support health services including staffing, environment, and community collaboration.

This study is descriptive; it is not designed to capture individual child or family data or performance standards compliance. Data from this study will not be used for monitoring purposes. Instead this study will provide the Office of Head Start with a picture of what Head Start programs are working on and the areas in which further assistance may be needed.

As part of this study, we asked all health managers within EHS/HS programs to complete an on-line survey. We are also conducting interviews with a small number of health managers, family service workers, teachers and home visitors to gain a better, more in-depth understanding of the health services area within HS. This phone interview will take about 45 minutes.

The risk to participation in this study is minimal. In any written reports of the data obtained from this survey, your responses will be combined with others and reported together. If quotations are used in any reports, they will not be connected to an individual or grantee. Identifiable information that you provide (e.g., name, program) will not be shared with anyone outside of the RAND project staff without your permission, except as required by law. At the end of the study, we will destroy any information that identifies you as a participant. There may be questions for which you do not have answers, but as stated earlier, we will not identify your name in any report.

Although there are no immediate benefits to you for answering the following questions, results from this study are expected to yield benefits to you in the future in your role as health manager. Your participation in this study will provide important information that will help Head Start improve the health services area and the support, training, and technical assistance that you receive to enhance your health programming.

Taking part in this survey is voluntary and you may choose to skip any questions that you do not want to answer. While your participation is voluntary, we do hope you will decide to contribute to this important study. Your participation is extremely important to ensure that we capture what is occurring in Head Start programs.

If you have any questions or comments about the study please contact Lynn Karoly (Lynn_Karoly@rand.org, 703-413-1100 x 5359) or Laurie Martin (Laurie_Martin@rand.org, 703-413-1100 x 5083). If you have any questions about your rights as a research participant, you may contact Tora Bikson, Administrator, RAND Human Subjects Protection Committee by phone at (310) 393-0411 or by email: Tora_Bikson@rand.org.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0970-0415. The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

Do you agree to participate in this study?

Yes → proceed to survey

No → Thank you for your consideration

A. CONTACT INFORMATION

Interviewer: Before we begin, it would be helpful to obtain some information on your background and role in the Head Start program.

CON1: Name _____

CON2: Please indicate your role in the Head Start Program

a. Teacher
b. Family Service Worker
c. Home Visitor

CON2a: Do you work in the home with families?

1. Yes
2. No

How often do you go into the home?

1. Several times a week
2. Once a week
3. A few times a month

4. Once a month
5. Every few months
6. Annually

CON3: Head Start Program Name_____

CON4: How long have you worked in this Head Start program in this role?

_____ years

CON5: How long have you worked in Head Start programs, whether in this role or in another program?

_____ (cumulative) years

CON6: What is the highest grade or year of school that you completed? [FACES, collapsed response categories]. ***Select one***.

12. Less than a high school diploma/equivalent (GED)
13. High school diploma/equivalent (GED)
14. Vocational/tech program after high school but no vocational/tech diploma
15. Vocational/tech diploma after high school
16. Some college but no degree
17. Associate degree
18. Bachelor's degree
19. Graduate or professional school but no degree
20. Master's degree (MA, MS, MPH, MSN, MBA)
21. Doctorate degree (Ph.D., Ed.D.)
22. Other Postgraduate Degree (Medicine/Md; Dentistry/Dds; Law/Jd/Llb; Etc.)

CON7. Please describe any health training that you have received in the past 3 years? What were the topics, how often, etc.? [*Interviewer check from this list, or use as probe.*]

<u>Physical Health/Oral Health</u>

a. Diabetes
b. Overweight (BMI over the 85th and below the 95th percentile) and Obesity (BMI above the 95th percentile)
c. Underweight or stunting or failure to thrive
d. Asthma or other lung disease
e. Vision conditions
f. Hearing conditions
g. Ear infections
h. Lead poisoning
i. Tuberculosis
j. Anemia (e.g., sickle cell, low iron)
k. Infectious diseases
l. Proper use or administration of medication, medical equipment, or medical supports
m. Other physical health problem (specify) _____
n. Tooth decay or cavities
o. Other dental health problem (specify)_____

<u>Behavioral Health and Developmental Delay</u>

p. Child neglect or abuse
q. Family violence

r. Substance abuse (e.g., alcohol, illicit drugs)
s. ADHD or ADD
t. PTSD (post traumatic stress disorder)
u. Depression
v. Anxiety
w. Autism spectrum disorders
x. Developmental delays (including language delays)
y. Other behavioral health problem (specify)_____

Prevention and Wellness

z. General health promotion or wellness
aa. General child development
bb. Oral Hygiene (e.g., brushing teeth)
cc. Immunizations
dd. Nutrition or healthy eating practices
ee. Physical activity or fitness
ff. Food safety
gg. Injury prevention and safety (e.g., dog bites, motor vehicle safety)
hh. CPR and other first aid
ii. Preventing spread of infectious disease (e.g., hand washing, covering mouth when cough)
jj. Head lice
kk. Bed bugs
ll. Environmental concerns (e.g., pesticide, lead poisoning, second hand smoke)
mm. Prenatal or postpartum issues
nn. Emergency preparedness
oo. Universal precautions
pp. Health literacy or health communication
qq. Other prevention or wellness topic (specify)_____

CON8: Did you ever have a child in your household who attended EHS/HS? [FACES]

1. Yes
2. No

CON9: Interviewer Name _____

CON10: Interview Date and Time _____

B. MEETING THE HEALTH NEEDS OF STUDENTS AND FAMILIES

Interviewer: To start, we would like to learn more about your experience in addressing the health needs of students in the Head Start program. This may include your experience in helping to manage the health conditions of medically fragile students or students with chronic illnesses (this includes range of physical and behavioral health issues, of ranging severity).

MHN1. What has been your experience in working with children with chronic health issues or children deemed as medically fragile?

[If family service worker/home visitor who conducts home based activity:]

When you go to the home to work with families on health issues, what does this entail? What types of activities are you doing for children with chronic health issues, if any?

Probe (for teachers/family service workers/home visitors):

- *What are the health issues that you see (e.g., asthma, behavioral health problems)?*
- *What is your role in addressing the health needs of these children? Medication administration?*
- *How do you work with the Health Manager or health staff to support or address the health needs of these children? (e.g., discuss in staff meetings, share classroom or home visit notes for child's health file, other)*
- *How do you communicate with parents/other family members about the health issues of these students? (also probe on culture, language issues where appropriate, developing relationship with family/having a foundation/history with the family)*

MHN2. What factors make the process of addressing the health needs of these children easier? What factors make the process more difficult?

[*For teachers:*]

In particular, do you have any difficultly in balancing the needs of children with health issues in your classroom, relative to conducting your class? Are there any disruptions, and if so, how is this managed? Are there benefits?

[*If family service worker/home visitor who conducts home based activities:*]

When you go to the home to work with families, what factors make the process easy and/or difficult [*Probe*: *Safety issues, family receptivity, other?]*

MHN3. What training or other resources have you had to assist you in addressing or managing the health needs of these students? Please describe where you received this, topics, how often, etc. Is this training enough? What more would you want/need?

MHN4. All children in Head Start/Early Head Start go through screenings and assessments when they enter the program.

- Do you help to ensure that these screenings and assessments are completed? How do you do this?

Some children end up needing referrals and further treatment.

- How do you help with referrals? With treatment? Do you help to track whether the children have completed all necessary screenings, assessments, and received treatment? How do you do this tracking? With what mechanism (child's files, computer tracking program, etc.)?

C. HEALTH SERVICES ADVISORY COMMITTEE

Interviewer: Next, we'd like to delve a bit more into any role that you may have on the Health Services Advisory Committee (HSAC).

HSC1. Are you involved in the HSAC? If so, what is your role?

[If answer is no, skip to section D.]

HSC2. How well do you think the HSAC has performed in the following areas? Describe successes/accomplishments in these areas:

[Note areas should be selected based on role of teacher vs. family service worker/home visitor.]

a. Develops comprehensive health promotion programs for HS children, families, and staff
b. Helps to develop health policies and procedures that support the health goals for HS children, families, and staff
c. Engages parents in identifying and accessing sources of continuous, accessible health care
d. Supports parents in becoming advocates for their children's health
e. Supports parents as leaders in efforts to improve the health of their community
f. Informs your program about current and emergent health issues, trends, and best practices
g. Develops long- and short-term goals and objectives and strategies for implementing services that meet the needs of the community
h. Advocates for community systems changes that support the health of the children and families in your program
i. Helps to establish ongoing, collaborative partnerships with community organizations
j. Educates health care providers, other professionals, and community leaders or policy makers on the needs and issues of HS/EHS/MS/AIAN children and families
k. Other (specify)_____

HSC3. Sometimes there is a real or perceived power differential between parents and professional service providers (e.g., physicians) on the Health Services Advisory Committee. What steps do you take to ensure that parents have a voice at the table? Feel comfortable participating?

D. IMPLEMENTING HEALTH ACTIVITIES

Interviewer: Next, I'd like to hear a bit more about your role in planning and/or implementing health activities in your Head Start program (in the classroom or home), with the Health Manager or other health staff. By health activities, we'll mainly focus on health promotion activities (anything that focuses on promoting healthy behaviors, and reducing the risk of disease or illness).

IMP1. Do you participate in implementing health promotion activities in the classroom/program? If so, what types of health promotion activities have you been a part of?
Probe:

- *Health topics*
- *What the activity(ies) entailed (e.g., curriculum, family activity, other)• Who is part of the activity? Parents, children?*

[If family service worker/home visitor who conducts home based activities:]

Do you participate in implementing health promotion activities in the home? If so, what types of health promotion activities have you (do you) conducted?
Probe:

- • *Health topics (e.g., teeth brushing, healthy eating)*
- • *What the activity(ies) entailed (e.g., curriculum, family activity, other)*
- • *Who is part of the activity? Parents, children?*

IMP2. Were you part of the selection of the topics and/or activities with the health staff? Describe that process. What training did you receive on the activities (probe for duration, intensity, frequency)? Was the training sufficient? What did you still need?
Probe:

- *Introduction to health activity (by health manager or other health staff), training*
- *Prior experience with implementing health promotion activity*

IMP3. When you implement health promotion activities, how do you roll-out the activity in your classroom/families home? From your perspective, what has worked well in this process? What impedes roll-out? (e.g., staff buy in, child receptivity, activity quality, parent buy in, culture/language, other?)

IMP4. What training or other supports would facilitate (or ease) future implementation of health promotion activities? [*Prompt:* In classroom, in home as relevant.]

IMP5: Working with families:

1. What health needs do you see that families have?
2. What health topics do you work on? Are any of these parent specific? Are there health topics or needs that you feel are not being met that you would like to work on with families? What supports do you have/need for working with families?
3. What is challenging with working with families around health? How do you address those challenges?
4. What are the successes you have had in working with families? How did you get there? What supports did you use/have?
5. What training would be helpful for you in working with families around health?

E. PARTNERSHIPS WITH COMMUNITY PROVIDES AND OTHER STAKEHOLDERS

Interviewer: Next, we'd like to learn a bit more about how you engage with community health providers and the extent to which you engage in the broader network of community services to support your Head Start families.
[This may only be relevant for family service workers, who may play a role in partnership development. Please build on prior responses to determine which questions may be appropriate.]

PRT1. Are you involved in engaging health providers to support health services in your program? To support health promotion activities in your program? If yes, what is your role? What has facilitated that process? What has made it difficult to engage health providers? What is the level of effort to engage and sustain these partnerships?

PRT2. Do you link with community health activities to support the health activities within Head Start (e.g., health fairs)? If so, how did that linkage come about (e.g., HSAC, you or staff participate in other community coalitions or boards)? If not, why not?

What about related health supports, such as social services (employment support for families, education, other)?

PRT3. How would you characterize your programs partnerships with community organizations to support Head Start health activities? Do you feel that your Head Start program is well-integrated into the community service network?

PRT4. Are there particular partnerships that you would like to have, and your program has not been able to forge? If so, what are they, and what has impeded that partnership to date?

F. TRAINING/SUPPORT FOR HEALTH STAFF AND HEALTH ACTIVITIES

Interviewer: Finally, we would like to learn more about other training or resources that would help you in your efforts to support health in your Head Start program.

TSP1. What training topics would benefit you as a [teacher/family service worker/home visitor] in support health activities in your program? What level of training would be helpful (duration/intensity/frequency)?

[Build on answers from Sections B, D as relevant.]

TSP2. What other resources or support would help you in these areas:

- Addressing the needs of children living with a chronic illness, children with medical fragility
- Supporting health promotion activities in your program, in the home (if relevant)
- Addressing staff well-being or health needs of staff
- Linking with community partners to support HS health activities and education
- Other?

Appendix F. Sources of Geocoded Data

This appendix provides additional detail on the sources and measures for the geocoded data referenced in Chapter Two. Table F.1 provides a list of the measures employed, organized by topics. For each measure, we provide a detailed descriptor and identify the data source, including the reference year. The level of geography is also specified. In many cases, the measures were obtained from the Robert Wood Johnson Foundation (RWJF) County Health Rankings online database (RWJF, 2015). The data in Table F.1 were extracted from the referenced sources between March 2014 and January 2015.

The first panel of measures, the demographic indicators, all are all county-level indicators derived from the pooled 2008–2012 American Community Survey (ACS) (U.S. Census Bureau, undated). The economic indicators in the second panel of measures for economic status are likewise county-level indicators from the 2008–2012 ACS. The county-level child health indicators in the third panel originate from the National Center for Health Statistics (NCHS) and the U.S. Department of Agriculture (USDA) Food Environment Atlas (USDA, undated), while the adult health indicators in the fourth panel derive from the Centers for Disease Control and Prevention (CDC), including the Behavioral Risk Factor Surveillance System (BRFSS). The county-level infrastructure and health-related environment measures also come from multiple sources—U.S. Bureau of Census, USDA Food Environment Atlas, County Business Patterns (CBP), the RWJF, CDC Wide-ranging Online Data for Epidemiologic Research (WONDER), Environmental Protection Agency (EPA) Safe Drinking Water Information System (SDWIS), and the Federal Bureau of Investigation (FBI) Uniform Crime Reports. The measures of health care shortages at the county level are produced by the Health Resources and Services Administration (HRSA) (HRSA, undated). Finally, the geocoded provider and facility data in the final panel derive from HRSA (undated), National Center for Education Statistics Integrated Postsecondary Education Data System (IPEDS) (National Center for Education Statistics, undated-b), and Substance Abuse and Mental Health Services Administration (SAMHSA) (provided to the authors).

The geocoded data in Table F.1 were linked to the 2,778 HS/EHS grantees and delegate agencies using a two-step process. OHS provided us with a geocoded list of the centers (or sites) in operation as of March 2013, midway through the program year, when the online Director Survey and Health Manager Survey were fielded. Each center record had the latitude and longitude for its location, as well as the number of funded HS/EHS slots. We matched each center to the relevant county-level measures in Table F.1. For the geocoded health care resource measures in the last panel of Table F.1, we calculated the distance between each center and the specific resource and classified the distance into specific ranges (e.g., zero to five miles, five to ten miles, ten to 20 miles, 20 to 30 miles, and more than 30 miles). We then aggregated across

the centers in each program to obtain a grantee or delegate agency measure. The aggregation used was a simple average—i.e., each center was weighted equally.[34] This means that for programs where all centers are in the same county, the program characteristics will be the same as the county characteristics. For programs with centers in more than one county, the program characteristics will be a weighted average of the characteristics for the counties where the centers are located, where each center receives equal weight. In the case of the distance measures, the program-level measure will reflect the proportion of the program's centers within each distance range.

In the frame of 2,778 HS/EHS programs, a match to geocoded data could not be made for 11 programs because they did not have center-level information in the OHS database. Geocoded data could not be matched to another six programs because they are located in U.S. territories and the geocoded measures in Table F.1 were not available. In addition, for some of the measures in Table F.1, data are missing for specific states (or Puerto Rico) or for some counties.

[34] We also created the program-level aggregates where each center was weighted by the number of funded slots, but there was little difference in the program-level aggregates.

Table F.1. Geocode Measures, Sources of Data, and Level of Geography

Measures	Detailed Measures	Years and Sources	Geography
Demographics			
Age 0 to 5 (%)	Percentage of total population ages 0 to 5	2008–2012 ACS (Table B01001)	County
Race (% distribution)		2008–2012 ACS (Table B02001)	County
White alone	Percentage of total population white alone		
Black or African American alone	Percentage of total population black or African American alone		
American Indian/Alaska Native alone	Percentage of total population American Indian and Alaska Native alone		
Asian alone	Percentage of total population Asian only		
Native Hawaiian/other Pacific Islander alone	Percentage of total Native Hawaiian and other Pacific Islander alone		
Some other race alone or two or more races	Percentage of total population some other race alone or two or more races		
Ethnicity (% distribution)		2008–2012 ACS (Table B03003)	County
Hispanic	Percentage of population Hispanic		
Not Hispanic	Percentage of population not Hispanic		
Language spoken at home (% distribution)		2008–2012 ACS (Table B16001)	County
English only	Percentage of population 5 years and older speaks English only at home		
Other language and speaks English very well	Percentage of population 5 years and older speaks other language at home and English very well		
Other language and speaks English less than very well	Percentage of population 5 years and older speaks other language at home and English less than very well		
Other language and speaks English not very well	Percentage of population 5 years an older speaks other language at home and English not very well		
Family households headed by single parent (%)	Percentage of total family households headed by single parent with children under 18	2008–2012 ACS (Table B11005)	County
Economic Status			
Median household income ($)	Median household income in the last year (2005 inflation-adjusted dollars)	2008–2012 ACS (Table B19013)	County
Poverty rate (%)	Percentage of population with family income less than poverty	2008–2012 ACS (Table B17001)	County
Poverty rate of children under 18 (%)	Percentage of children under 18 with family income less than poverty	2008–2012 ACS (Table B17001)	County
Poverty rate of children under 5 (%)	Percentage of children ages 0–4 with family income less than poverty	2008–2012 ACS (Table B17001)	County
Children under 6 without health insurance (%)	Percentage of children under 6 without health insurance	2008–2012 ACS (Table B27001)	County

Table F.1. Geocode Measures, Sources of Data, and Level of Geography, *Continued*

Measures	Detailed Measures	Years and Sources	Geography
Child Health Indicators			
Low birth weight (%)	Percentage of birth weights of less than 2,500 grams	2004–2010 NCHS[a]	County
Obesity rate for low-income preschool children (%)	Percentage of children ages 2 to 4 in households with income up to 200% of poverty who are obese (BMI for age > 95th percentile)	2014 USDA Food Environment Atlas	County[c]
Teen birth rate (per 1,000 births)	Number of births to women ages 15–19 per 1000	2004–2010 NCHS[a]	County
Adult Health Indicators			
Adults in poor/fair health (%)	Percentage of adults age 18 and older with self-reported poor or fair health	2005–2011 CDC BRFSS[a]	County
Adult days per month of poor physical health	Average number of days per month of self-reported poor physical health for adults age 18 and older	2005–2011 CDC BRFSS[a]	County
Adult days per month of poor mental health	Average number of days per month of self-reported poor mental health for adults age 18 and older	2005–2011 CDC BRFSS[a]	County
Adult obesity rate (%)	Percentage of adults age 20 and older with self-reported BMI ≥ 30	2009 CDC, Division of Diabetes Translation[a]	County
Adults with no leisure-time physical activity (%)	Percentage of adults age 20 and older who report no leisure-time physical activity	2009 CDC, Division of Diabetes Translation[a]	County
Adult smoking rate (%)	Percentage of adults age 18 and older who report smoking more than 100 cigarettes in their lifetimes and are still smoking	2005–2011 CDC BRFSS[a]	County
Adults without social/emotional support (%)	Percentage of adults age 18 and older who report no social or emotional support	2005–2010 CDC BRFSS[a]	County

Table F.1. Geocode Measures, Sources of Data, and Level of Geography, *Continued*

Measures	Detailed Measures	Years and Sources	Geography
County Infrastructure and Health-Related Environment			
Urban/rural status	Census tract is urban, urban cluster, or rural	Census TIGER/Line	Census tract
Limited access to healthy foods (%)	Percentage of population with limited access to healthy foods	2012 USDA Food Environment Atlas[a]	County
Fast food restaurants (%)	Percentage of restaurants in the county that are classified as fast food (i.e., transactions typically occur at a drive-through window or walk-up counter)	2010 CBP[a]	County
Recreational facilities (per 100,000 persons)	Number of recreational facilities per 100,000 persons in a given county	2010 CBP[a]	County
Parks (per 100,000 persons)	Number of parks per 100,000 persons: This is the percentage of population with park access (the data set was created by buffering a half-mile radius of all parks at the census block level, aggregated to the county level, then divided by the total number of people in that county)	2010 RWJF County Health Rankings	County
Average daily pollution (micro grams/cubic meter)	Average daily amount of fine particulate matter (micrograms/cubic meter)	2008 CDC WONDER[a,]	County[d]
Water violations rate (%)	Percentage of population exposed to water exceeding a violation limit in the past year	2012 EPA SDWIS[a]	County[e]
Violent crime rate (per 100,000 persons)	Number of violent crimes per 100,000 persons	2008–2010 FBI Uniform Crime Reports[a]	County
County Health Care Shortages			
Has a medically underserved area (%)	County has one or more medically underserved areas, defined as an area where the Index of Medical Underservice is 62.0 or below[f]	2013 HRSA	County
Has a shortage area of primary care health professionals (%)	County has one or more shortage areas of primary care health professionals, defined as having a physician-to-population ratio exceeding 1:3,500	2013 HRSA	County
Has a shortage area of mental health professionals (%)	County has one or more shortage areas of mental health professionals, defined as having a psychiatrist-to-population ratio exceeding 1:30,000	2013 HRSA	County
Has a shortage area of dental health professionals (%)	County has one or more shortage areas of dental health professionals, defined as having a dentist-to-population ratio exceeding 1:5,000	2013 HRSA	County

Table F.1. Geocode Measures, Sources of Data, and Level of Geography, *Continued*

Measures	Detailed Measures	Years and Sources	Geography
County Geocoded Health Care Resources			
Hospitals	Addresses of all hospitals, including critical access hospitals, crucial access hospitals, short term, psychiatric, rehabilitation	2013 HRSA	Latitude and longitude
FQHCs	Addresses of all FQHCs	2013 HRSA	Latitude and longitude
Medical colleges	Addresses of postsecondary education institutions with a professional designation of medicine, health and wellness, health services/allied, or health/health sciences	2012 IPEDS	Latitude and longitude
Dental schools	Addresses of postsecondary education institutions with a professional designation of advanced general dentistry, dental support, orthodontics, periodontics, or prosthodontics	2012 IPEDS	Latitude and longitude
Mental health or social health schools	Addresses of postsecondary education institutions with a professional designation of clinical counseling, community health services liaison, genetic counseling, marriage and family therapy, mental health counseling, psychiatric/mental health services, psychoanalysis and psychotherapy, or substance abuse/addiction counseling	2012 IPEDS	Latitude and longitude
Mental health professionals accepting Medicaid		2014 SAMHSA	Latitude and longitude
Outpatients only	Addresses of mental health facilities accepting Medicaid for outpatients only		
Adult outpatients only	Addresses of mental health facilities accepting Medicaid for adult outpatients only		
Child outpatients only	Addresses of mental health facilities accepting Medicaid for child outpatients only		

SOURCES: As indicated in source column.
[a] Measure obtained from the RWJF.
[b] Measure obtained from HRSA.
[c] Data are missing for counties in Arkansas, Delaware, the District of Columbia, Michigan, Oklahoma, South Carolina, and Wyoming.
[d] Data are missing for counties in Alabama and Hawaii.
[e] Data are missing for Hawaii.
[f] The Index of Medical Underservice ranges from 0 (completely underserved) to 100 (best served), based on four variables: the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with income below the poverty level, and percentage of the population age 65 or over.

Table F.2 documents the missing data rates for each geocoded measure. The missing data rates are shown for all 3,221 counties and separately for the 3,007 counties with at least one HS/EHS center and for the remaining 214 counties without any centers. At the county level, missing data rates are highest for the adult health indicator measures, reaching a maximum of 23 percent. Missing data rates tend to be higher in the counties without an HS/EHS program, but that is not always the case.

The final column shows the missing data rates in our frame of 2,778 HS/EHS grantees and delegate agencies. These missing data rates reflect the 17 cases with no match to county-level data, as well as those cases that we match to county-level data but the measure is missing for that county. While the missing data rate is relatively high for the 3,007 counties with HS/EHS programs, the corresponding missing data rate in our frame of 2,778 HS/EHS programs tends to be lower (at most 9 percent and typically 3 to 4 percent), indicating that HS/EHS programs are overrepresented among the counties with nonmissing data.

As noted in Chapter Two, one of the geocoded measures we use to stratify programs is a measure of urbanicity, the one measure in Table F.1 that is matched based on census tract. After assigning each center an indicator that it is in a census tract classified as an urban area or urban cluster versus a census tract that is classified as a rural area, we aggregate across centers to measure the percentage of centers for each grantee or delegate agency that are in an urban area or urban cluster. We then classified programs into one of three strata: having centers mostly in rural areas (0 to 20 percent of centers in a census-designated urban area or urban cluster), in mixed areas (21 to 80 percent of centers in an urban area or urban cluster), or mostly in urban areas (81 to 100 percent of centers in an urban area or urban cluster). Table F.3 reports the distribution of programs and delegate agencies into a more disaggregated set of categories, starting with 0 percent (all centers in rural areas) and ending with 100 percent (all centers in urban areas or urban clusters). This detailed distribution is shown for all programs, separately for HS and EHS programs, and for all programs in Region XI and Region XII.

Table F.2. Missing Data Rates for Geocoded Measures

Measures	Percentage of Counties with Missing Data (%)			Percentage of HS/EHS Programs with Missing Data
	All Counties	Counties with HS/EHS Programs	Counties Without HS/EHS Programs	
Demographics				
Ages 0 to 5	0.0	0.0	0.0	0.6
Race	0.0	0.0	0.0	0.6
Ethnicity	0.0	0.0	0.0	0.6
Language spoken at home	0.0	0.0	0.0	0.6
Family households headed by single parent	0.1	0.0	0.9	0.6
Economic status				
Median household income	0.0	0.0	0.0	0.6
Poverty rate	0.0	0.0	0.0	0.6
Poverty rate of children under 18	0.1	0.0	0.9	0.6
Poverty rate of children under 5	0.1	0.0	1.4	0.6
Children under 6 without health insurance	0.1	0.0	1.4	0.6
Child health indicators				
Low birth weights	9.3	5.9	57.5	3.1
Obesity rate for low-income preschool children	15.7	12.9	55.6	9.3
Teen birth rate (per 1,000 births)	8.2	5.2	50.0	3.1
Adult health indicators				
Adults in poor/fair health	14.9	14.0	28.5	4.4
Adult days per month of poor physical health	10.2	9.1	24.3	3.7
Adult days per month of poor mental health	11.2	10.2	25.2	3.7
Adult obesity rate	2.6	2.7	0.5	3.0
Adults with no leisure-time physical activity	2.6	2.7	0.5	3.0
Adult smoking rate	21.4	20.3	36.0	5.2
Adults without social/emotional support	23.4	22.1	41.1	6.2
County infrastructure and health-related environment				
In an urban area or urban cluster	0.0	0.0	0.0	0.4
Limited access to healthy foods	2.6	2.7	0.5	3.0
Fast food restaurants	7.3	5.3	35.5	3.4
Recreational facilities (per 100,000 persons)	2.6	2.7	0.5	3.0
Parks (per 100,000 persons)	13.4	12.8	21.5	5.3
Average daily pollution (micrograms/cubic meter)	3.5	3.6	3.3	4.9
Water violations rate	4.3	4.3	4.7	6.5
Violent crime rate (per 100,000 persons)	7.9	7.4	15.0	4.2
County health care resources				
Has a medically underserved area	2.4	2.6	0.0	3.0
Has a primary care health professional shortage area	2.4	2.6	0.0	3.0
Has a mental health professional shortage area	2.4	2.6	0.0	3.0
Has a dental health professional shortage area	2.4	2.6	0.0	3.0
Number of counties	3,221	3,007	214	2,778

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's geocoded data.
NOTE: Results are unweighted.

Considering the two extremes, Table F.3 shows that 9 percent of all programs have all centers in rural areas, while 49 percent of programs have all centers in urban areas. The remaining programs are distributed along the continuum, with centers mostly in rural areas to mostly in urban areas, with some falling in between. This same pattern holds for HS programs

and EHS programs, although the latter have somewhat greater concentration of programs with all centers in an urban area. The sharpest contrast is for Region XI AIAN programs, where 68 percent have all centers in rural areas, and just 12 percent have all centers in urban areas. Compared with all programs, Region XII MSHS programs have a somewhat higher share of programs with centers in all rural areas, a lower share of programs with centers in all urban areas, and a greater concentration of programs with centers in both rural and urban areas.

Table F.3. Distribution of Programs by Urbanicity: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
In an urban area or urban cluster (%)	73.8	70.2	80.1	18.9	63.5
In urban area or urban cluster (% distribution)					
0 percent	9.1	9.4	8.5	68.0	16.7
1 to 10 percent	0.4	0.6	0.1	1.0	1.5
11 to 20 percent	2.1	2.6	1.1	5.1	1.5
21 to 30 percent	3.0	3.8	1.5	2.0	3.0
31 to 40 percent	4.6	5.9	2.4	5.1	1.5
41 to 50 percent	6.9	7.4	6.1	4.1	4.5
51 to 60 percent	3.9	4.9	2.1	1.0	4.5
61 to 70 percent	6.1	6.6	5.4	1.0	16.7
71 to 80 percent	6.6	7.3	5.4	1.0	13.6
81 to 90 percent	5.4	6.2	4.0	0.0	3.0
91 to 99 percent	3.2	4.2	1.5	0.0	7.6
100 percent	48.7	41.1	62.0	11.7	25.8
Number of programs	2,778	1,767	1,011	198	67
Number of programs with missing value	11	6	5	1	1

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's geocoded data.
NOTES: Results are unweighted. For each HS or EHS grantee or delegate agency, the census track measure of urbanicity was first matched to the program's centers and then averaged across all centers in the program to obtain the average value for the grantee or delegate agency. A total of 11 programs could not be matched to the census track measure of urbanicity (six HS programs, five EHS programs, and one each in Region XI and Region XII).

Appendix G. Director Survey Responses

This appendix provides tabulations, by program type, for the director responses to the online Director Survey that are not otherwise tabulated in the body of the report. These include the respondent's

- demographic characteristics (Table G.1)
- highest educational attainment (Table G.2)
- coursework and degrees by field (Table G.3)
- health-related licenses, certificates, and credentials (Table G.4)
- prior HS/EHS positions held (Table G.5)
- years of prior experience in specific settings (Table G.6)
- roles (Table G.7)
- roles with the HSAC (Table G.8).

In most tables, results are reported for programs in all regions, for HS programs in all regions, for EHS programs in all regions, and for Region XI and Region XII programs. In all tables, the unit of analysis is the HS/EHS grantee or delegate agency so that a director's responses may contribute more than one observation if he or she serves as director for more than one program. Weights are used for all tabulations to account for nonresponse, so the results are representative for all HS/EHS grantee and delegate agencies.

In reviewing the tabulations, it is important to keep in mind that, in some cases, a proxy respondent completed the Director Survey when the director was not available or otherwise occupied. The survey did not identify such cases to determine the incidence of proxy respondents or to exclude them from tabulations. With a proxy respondent, it is not clear whether the respondent completed information about the director's background using the director's characteristics or the proxy respondent's own characteristics. For this reason, some caution should be applied in interpreting the Director Survey tabulations presented in this appendix.

Table G.1. Directors' Characteristics: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Sex (% distribution)					
Female	89.2	88.6	90.2	88.2	81.0
Male	10.8	11.4	9.8	11.8	19.0
[Missing]	*12.8*	*12.6*	*13.1*	*12.4*	*5.5*
Age (% distribution)					
Younger than 25	0.1	0.1	0.2	0.0	0.0
25 to 34	5.4	5.4	5.5	5.5	5.9
35 to 44	19.8	18.6	21.7	23.4	17.8
45 to 54	28.5	29.0	27.6	31.8	26.0
55 to 64	37.5	37.7	36.9	31.9	42.3
65 or older	8.7	9.2	7.9	7.2	7.9
[Missing]	*13.0*	*12.9*	*13.1*	*11.7*	*9.1*
Hispanic, Latino/a, or Spanish origin (%)					
No	88.6	88.9	88.4	92.7	68.2
Yes	11.4	11.1	11.6	7.3	31.8
Yes, Mexican, Mexican American, Chicano/a	4.1	4.0	4.3	2.5	20.4
Yes, Puerto Rican	3.1	3.2	2.9	0.0	0.0
Yes, Cuban	0.2	0.2	0.1	0.0	0.0
Yes, Another Hispanic, Latino/a, or Spanish origin	3.9	3.7	4.4	4.8	11.4
[Missing]	*13.3*	*13.1*	*13.5*	*14.4*	*5.5*
Race (%)					
White	72.4	71.7	73.6	33.4	83.9
Black or African American	18.5	18.9	17.7	0.7	8.9
American Indian or Alaska Native	6.9	7.2	6.2	63.8	7.2
Asian or South Asian	1.8	1.6	2.3	2.1	0.0
Other	0.4	0.6	0.2	0.0	0.0
[Missing]	*13.5*	*13.2*	*14.1*	*12.4*	*5.5*
English proficiency (% distribution)					
Speak English very well	96.9	97.0	96.8	97.6	100.0
Speak English well	2.6	2.5	2.8	2.4	0.0
Speak English not well	0.2	0.2	0.1	0.0	0.0
Speak English not at all	0.2	0.2	0.3	0.0	0.0
[Missing]	*12.7*	*12.6*	*13.0*	*11.7*	*5.5*
Speaks a language other than English at home (% distribution)					
No	85.2	85.2	85.2	84.1	68.9
Yes	14.8	14.8	14.8	15.9	31.1
[Missing]	*12.8*	*12.6*	*13.0*	*11.7*	*7.3*
Has or had a child who attended HS/EHS (% distribution)					
Yes	27.6	30.0	23.4	67.1	26.0
No	72.4	70.0	76.6	32.9	74.0
[Missing]	*13.0*	*12.8*	*13.2*	*11.7*	*9.1*
Number of director respondents	1,627	1,412	852	107	43

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table G.2. Directors' Highest Educational Attainment: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Highest education level (% distribution)					
Up to high school diploma/GED	0.5	0.6	0.2	1.6	0.0
Vocational/technical diploma	1.7	1.7	1.8	0.0	1.9
Some college, no degree	4.0	4.6	2.7	11.1	0.0
Associate degree	6.4	7.0	5.5	18.6	11.5
Bachelor's degree	30.2	30.6	29.6	29.6	30.7
Graduate/professional school, no degree	7.7	7.2	8.4	6.9	1.9
Master's degree	49.6	48.4	51.7	32.3	54.0
[Missing]	11.5	11.1	12.2	11.7	5.5
Number of director respondents	1,627	1,412	852	107	43

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table G.3. Directors' Coursework and Degrees by Field: By Program Type

Fields of Study	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Child health (% distribution)					
No courses in field	9.9	10.1	9.8	12.6	12.1
Some courses in field	53.4	54.7	51.2	50.9	62.0
Associate degree in field	9.2	9.3	9.1	15.7	6.2
Bachelor's degree or higher in field	27.4	25.8	29.9	20.7	19.7
[Missing]	*13.5*	*13.4*	*13.6*	*13.0*	*9.1*
Special needs (% distribution)					
No courses in field	20.4	21.0	19.3	18.7	24.0
Some courses in field	60.7	60.3	61.2	60.8	63.9
Associate degree in field	5.1	5.0	5.2	8.7	8.0
Bachelor's degree or higher in field	13.9	13.8	14.3	11.8	4.1
[Missing]	*14.1*	*14.1*	*13.9*	*12.4*	*9.1*
Medicine (% distribution)					
No courses in field	78.2	78.6	77.7	78.9	71.6
Some courses in field	16.2	15.9	16.9	18.6	14.2
Associate degree in field	4.0	4.0	4.0	1.7	12.2
Bachelor's degree or higher in field	1.5	1.5	1.4	0.8	2.0
[Missing]	*15.5*	*15.5*	*15.5*	*15.8*	*10.9*
Nursing (% distribution)					
No courses in field	77.9	78.2	77.2	78.9	70.0
Some courses in field	9.6	9.7	9.4	14.5	7.9
Associate degree in field	7.3	7.2	7.8	6.6	14.1
Bachelor's degree or higher in field	5.2	4.9	5.6	0.0	8.0
[Missing]	*14.9*	*14.9*	*15.0*	*15.8*	*9.1*
Behavioral/mental health (% distribution)					
No courses in field	31.0	31.1	30.8	31.3	36.2
Some courses in field	52.2	52.6	51.5	55.0	49.9
Associate degree in field	2.9	2.7	3.3	3.3	2.0
Bachelor's degree or higher in field	13.9	13.6	14.4	10.4	11.9
[Missing]	*15.1*	*14.9*	*15.5*	*14.4*	*9.1*

Table G.3. Directors' Coursework and Degrees by Field: By Program Type, *Continued*

Fields of Study	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Social work (% distribution)					
No courses in field	38.2	38.4	37.8	46.5	34.9
Some courses in field	45.1	45.3	44.6	34.4	48.8
Associate degree in field	3.2	3.2	3.4	2.3	4.0
Bachelor's degree or higher in field	13.5	13.1	14.2	16.7	12.2
[Missing]	*14.6*	*14.6*	*14.5*	*14.4*	*10.9*
Health education (% distribution)					
No courses in field	38.4	37.9	39.2	47.5	44.7
Some courses in field	51.7	52.2	50.7	49.2	38.3
Associate degree in field	5.2	5.0	5.4	1.6	10.7
Bachelor's degree or higher in field	4.7	4.8	4.7	1.6	6.3
[Missing]	*15.1*	*14.9*	*15.4*	*15.1*	*14.7*
Nutrition (% distribution)					
No courses in field	36.4	36.5	36.3	40.0	38.1
Some courses in field	57.0	57.0	56.9	57.5	51.9
Associate degree in field	3.5	3.5	3.6	1.6	10.0
Bachelor's degree or higher in field	3.1	3.0	3.2	0.8	0.0
[Missing]	*14.8*	*14.7*	*14.9*	*14.4*	*9.1*
Physical fitness (% distribution)					
No courses in field	40.5	39.1	42.9	38.2	36.5
Some courses in field	55.4	56.5	53.2	59.4	61.5
Associate degree in field	2.1	2.0	2.5	0.8	2.0
Bachelor's degree or higher in field	2.0	2.4	1.4	1.6	0.0
[Missing]	*15.2*	*15.1*	*15.3*	*15.1*	*10.9*
Public/community health (% distribution)					
No courses in field	58.6	59.6	57.1	67.6	50.8
Some courses in field	34.2	33.7	35.1	30.7	33.0
Associate degree in field	2.4	2.1	2.8	0.0	2.0
Bachelor's degree or higher in field	4.8	4.6	5.0	1.6	14.1
[Missing]	*15.4*	*15.4*	*15.3*	*14.4*	*10.9*
Number of director respondents	1,627	1,412	852	107	43

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table G.4. Directors' Health-Related Licenses, Certificates, or Credentials: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Has health-related license, certificate, or credential (% distribution)					
No	71.4	71.8	70.9	76.5	57.8
Yes	28.6	28.2	29.1	23.5	42.2
[Missing]	*12.7*	*12.5*	*13.1*	*11.7*	*9.1*
Physician (MD) or osteopath (DO) (%)					
Currently have	0.2	0.0	0.5	0.0	0.0
Had one but not currently active	1.2	1.4	0.9	0.0	4.7
Registered nurse (RN) (%)					
Currently have	23.5	23.0	24.3	6.7	33.4
Had one but not currently active	1.4	1.4	1.3	0.0	0.0
Licensed practical nurse (LPN) (%)					
Currently have	10.8	10.2	11.9	19.8	14.2
Had one but not currently active	4.0	4.3	3.5	3.4	0.0
Licensed vocational nurse (%)					
Currently have	2.3	2.2	2.3	0.0	4.7
Had one but not currently active	1.0	1.1	0.9	0.0	0.0
Nurse practitioner (%)					
Currently have	0.5	0.5	0.5	0.0	0.0
Had one but not currently active	1.2	1.4	0.9	0.0	4.8
School nurse (%)					
Currently have	3.4	4.4	1.8	0.0	0.0
Had one but not currently active	2.3	2.1	2.6	0.0	4.8
Social worker or counselor (%)					
Currently have	15.8	13.7	19.4	16.4	14.4
Had one but not currently active	9.7	10.2	8.9	19.8	4.7
Psychologist or psychiatrist (%)					
Currently have	2.7	2.6	2.9	0.0	4.7
Had one but not currently active	1.4	1.7	0.9	0.0	0.0
Dentist or dental hygienist (%)					
Currently have	0.3	0.5	0.0	0.0	0.0
Had one but not currently active	1.4	1.6	0.9	0.0	0.0
Nutritionist (%)					
Currently have	2.5	2.5	2.4	0.0	0.0
Had one but not currently active	1.8	1.9	1.8	0.0	0.0
Other (%)					
Currently have	24.9	23.2	27.8	16.5	4.8
Had one but not currently active	6.5	6.9	5.7	13.3	0.0
Number of director respondents	1,627	1,412	852	107	43

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table G.5. Directors' Prior HS/EHS Positions Held: By Program Type

HS/EHS Positions	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
No previous positions held (%)	21.4	21.0	22.1	22.2	16.6
Prior positions held					
Percentage for each position (%)					
Health manager/coordinator	13.3	13.1	13.6	16.5	31.2
Teacher	24.1	25.6	21.4	29.7	14.5
Teacher's aide/instructional aide	7.9	9.0	5.9	17.3	9.1
Education manager/coordinator	21.3	21.4	21.1	20.0	12.7
Family service worker/home visitor	13.7	14.2	12.8	20.1	12.7
Outreach staff, recruiter, or enrollment manager/coordinator	7.3	7.7	6.6	9.6	9.1
Counselor	1.3	1.3	1.4	3.4	0.0
Disability manager/coordinator	14.5	14.9	13.9	17.9	19.9
Parent-involvement manager/coordinator	10.8	11.3	9.9	14.5	7.4
Behavioral health/mental health manager/coordinator	7.0	6.8	7.4	7.5	14.7
Nutrition manager/coordinator	6.8	7.2	6.2	10.2	9.2
Culinary or food services staff	1.5	1.5	1.4	3.4	5.4
Receptionist or office staff	3.3	3.9	2.3	6.3	1.8
Bus driver or related transportation	3.3	3.8	2.5	8.3	1.8
Director, associate director, or other program manager	21.1	19.8	23.5	17.2	14.4
Other	20.6	20.3	21.1	16.3	23.3
[Missing (%)]	*12.9*	*12.9*	*13.0*	*12.4*	*9.1*
Number of director respondents	1,627	1,412	852	107	43

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table G.6. Directors' Years of Prior Experience in Specific Settings: By Program Type

Settings	Years of Experience (percentage distribution)					
	None	Less Than 2 Years	3 to 5 Years	6 to 10 Years	11 to 24 Years	25 or More Years
A. All HS/EHS Directors						
Working with children ages 0 to 5 in a child care or education setting	2.3	4.1	6.7	12.8	39.4	34.8
Working in any HS/EHS program	12.0	7.7	11.3	16.4	35.8	16.9
Working in any HS/EHS AIAN program	87.8	2.8	1.8	2.2	3.8	1.6
Working in any HS/EHS MSHS program	86.6	4.2	2.7	2.2	2.8	1.4
Working as a health manager in an HS/EHS program	67.3	9.2	9.1	6.7	6.5	1.2
Working in a health care setting	72.0	9.3	6.8	5.8	3.7	2.3
B. Directors in HS Programs						
Working with children ages 0 to 5 in a child care or education setting	2.5	4.1	6.1	11.9	39.7	35.6
Working in any HS/EHS program	14.6	7.3	10.1	15.6	34.9	17.5
Working in any HS/EHS AIAN program	86.9	2.6	1.9	2.7	4.0	2.0
Working in any HS/EHS MSHS program	86.2	4.2	2.7	2.3	3.0	1.5
Working as a health manager in an HS/EHS program	67.2	8.9	9.1	6.5	7.0	1.3
Working in a health care setting	73.4	8.9	6.4	5.6	4.0	1.8
C. Directors in EHS Programs						
Working with children ages 0 to 5 in a child care or education setting	1.8	4.0	7.8	14.3	38.6	33.3
Working in any HS/EHS program	7.5	8.2	13.2	17.9	37.1	16.0
Working in any HS/EHS AIAN program	89.3	3.2	1.5	1.4	3.4	1.2
Working in any HS/EHS MSHS program	87.4	4.1	2.8	2.0	2.3	1.3
Working as a health manager in an HS/EHS program	67.5	9.9	9.2	6.8	5.6	1.0
Working in a health care setting	69.8	10.1	7.3	6.4	3.3	3.2
D. Directors in Region XI Programs						
Working in an HS/EHS AIAN program	0.8	7.7	12.6	24.2	37.9	16.8
E. Directors in Region XII Programs						
Working in an HS/EHS MSHS program	4.0	9.8	18.3	26.1	29.9	12.0

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey.
NOTES: Based on 1,627 director respondents: 1,412 in HS programs, 852 in EHS programs, 107 in Region XI programs, and 43 in Region XII programs). Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases range from 13 percent to 15 percent in panels A to C and equal 12 percent in panel D and 9 percent in panel E.

Table G.7. Director Roles: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Director roles (% distribution)					
Director role only	69.0	68.4	70.1	52.4	75.4
Director role and 1 other role	18.5	18.3	18.7	19.6	22.5
Director role and 2 or more other roles	12.5	13.3	11.2	28.1	2.1
[Missing]	*13.9*	*13.7*	*14.1*	*13.1*	*12.8*
If other roles, role(s) are (%)					
Teacher	3.0	3.3	2.4	7.0	0.0
Teacher's aide/instructional aide	3.3	4.1	1.9	8.6	0.0
Education manager/coordinator	18.1	18.9	16.8	24.0	0.0
Family service worker/home visitor	7.0	8.3	4.7	18.7	0.0
Outreach staff/recruiter/enrollment manager/coordinator	14.4	15.1	13.1	17.1	8.2
Counselor	2.4	2.7	1.9	1.7	0.0
Disability manager/coordinator	20.9	20.9	20.9	28.6	8.4
Parent-involvement manager/coordinator	11.2	11.5	10.5	15.3	0.0
Behavioral/mental health manager/coordinator	16.6	16.8	16.1	35.3	16.8
Nutrition manager/coordinator	20.7	21.0	20.2	24.0	8.4
Culinary or food services staff	5.4	5.8	4.7	8.4	0.0
Receptionist/office staff	5.9	7.3	3.3	13.8	0.0
Bus driver or related transportation	4.4	6.0	1.4	7.0	0.0
Director, associate director, or other program manager	19.1	20.5	16.5	30.3	8.6
Other role	49.0	49.0	49.1	51.1	66.5
Number of director respondents	1,627	1,412	852	107	43

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Table G.8. Director Roles with HSACs: By Program Type

Measures	All Regions, Total	All Regions, Head Start Only	All Regions, Early Head Start Only	Region XI, Total	Region XII, Total
Director is involved in activities related to HSAC (% distribution)					
Yes	95.0	94.8	95.6	94.6	96.2
No	5.0	5.2	4.4	5.4	3.8
[Missing]	*11.6*	*11.2*	*12.3*	*12.4*	*5.5*
If have involvement, activities are (%)					
Identifying potential members	83.6	83.4	84.0	81.6	82.0
Selecting members	56.5	56.0	57.4	52.3	59.9
Providing input on committee activities	84.9	84.3	86.0	90.0	73.8
Scheduling committee activities	46.6	47.5	45.1	50.8	49.9
Attending committee meetings	86.4	86.8	85.8	93.4	94.0
Other role	11.2	11.0	11.7	13.3	16.1
Number of director respondents	1,627	1,412	852	107	43

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Director Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. The percentages of missing cases are shown for reference.

Appendix H. Supplemental Survey Tabulations

This appendix provides subgroup tabulations for survey results appearing in Chapters Four to Fifteen (except Chapter Fourteen) for questions in the Director Survey and core questions in the Health Manager Survey. The three stratifying variables are based on the health manager health-related education background, program size, and program rural-urban status.

The health manager health-related education background was based on health managers' responses about their highest levels of education (see Table 3.2), the fields of their degrees (see Table 3.3), and their having health-related licenses, certificates, or credentials (see Table 3.4):

- No health-related education background (labeled "none" in the tables): This group has no postsecondary degree in a health-related field and no health-related license, certificate, or credential.
- Health-related associate degree or credentials (labeled "AA" in the tables): This group has no higher than an *associate* degree in a health-related field (includes child health, special needs, medicine, nursing, behavioral or mental health, social work, health education, nutrition, physical fitness, and public/community health) or an *associate* degree in some other field (or no degree) but a health-related license, certificate, or credential.
- Health-related bachelor's degree or credentials (labeled "BA" in the tables): This group has a bachelor's degree or higher in a health-related field or a bachelor's degree or higher in some other field along with a health-related license, certificate, or credential.

Programs were classified based on the classifications of their health managers. Programs with more than one health manager respondent were assigned to the highest category held across the responding health managers. The majority of programs fall into the third category (1,068 programs, or 56 percent). The first category has just 236 programs (12 percent), and the middle group has 467 programs (25 percent). This stratifying variable is missing for 131 programs (7 percent).

For program size, HS/EHS programs were stratified into roughly three equal-sized groups, based on the PIR field for funded enrollment. The three size categories and the number of programs in each group (among the 1,902 programs represented by the health manager respondents) are

- small: fewer than 150 funded slots (593 programs)
- medium: 151 to 349 funded slots (643 programs)
- large: 350 or more funded slots (656 programs).

The size measure is missing for ten programs.

Program urban-rural status was assigned based on the census urban-rural indicator at the census tract level (see Table F.1). Each center operated by an HS/EHS grantee or delegate agency was assigned, based on the geocoded address (i.e., latitude and longitude), as being in a

census tract that is rural, an urban cluster, or urban. Aggregating across all centers, each HS/EHS grantee or delegate agency was assigned to one of three categories:

- mostly rural (labeled "rural" in the tables): 0 to 20 percent of the centers are in an urban cluster or urban area
- mixed: more than 20 percent but less than or equal to 80 percent of centers are in an urban cluster or urban area
- mostly urban (labeled "urban" in the tables): more than 80 percent and up to 100 percent of the centers are in an urban cluster or urban area.

Among the 1,902 programs represented by the health manager respondents, the majority (1,030 or 54 percent) are in the mostly urban group. Another 35 percent (675 programs) are in the mixed group, and the remaining 10 percent (193 programs) are in the mostly rural group. Four programs do not have a census urban-rural designation.

As noted in Chapter Two, our purpose in conducting the subgroup analyses was descriptive. We did not seek to test specific hypotheses or explain the subgroup differences. Because of differences in the size of the subgroups, the magnitude of the standard errors associated with survey percentages will vary. The approximate standard errors to accompany these tables are found in Appendix B (Tables B.9, B.10, and B.11 for program size, health-manager background, and urban-rural status, respectively). With these standard errors in mind, the narrative discussion in the body of the report highlights the larger subgroup differences as the most meaningful.

In order to facilitate a comparison with the same survey questions reported in the body of the report, each table in this appendix is ordered to match the corresponding table in the report and numbered accordingly. Thus, Table H.4.1 corresponds to Table 4.1 in Chapter Four and so on. Because we only consider questions in the core survey, the table numbers are not consecutive.

Table H.4.1. Health Manager Roles: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Health manager roles (% distribution)										
HM role only	29.1	18.5	33.0	30.2	26.0	26.7	34.6	22.6	26.5	32.1
HM role and 1 other role	32.9	33.2	30.7	33.9	29.3	31.2	37.7	24.8	35.0	33.3
HM role and 2 or more other roles	38.0	48.4	36.3	35.9	44.7	42.1	27.7	52.6	38.5	34.6
If other roles, role(s) are (%)										
Teacher	0.9	0.9	1.5	0.6	1.6	0.9	0.2	0.2	0.2	1.5
Teacher's/instructional aide	1.7	1.8	2.4	1.3	4.0	0.4	0.6	4.8	0.1	2.0
Education manager/coordinator	4.8	11.4	2.6	4.1	8.5	3.7	1.9	6.1	3.4	5.3
Family service worker/home visitor	9.7	13.3	8.0	8.9	18.8	6.7	3.0	18.1	5.2	10.6
Outreach staff/recruiter/ enrollment manager/coordinator	8.1	17.5	4.0	7.4	14.8	4.4	5.1	10.4	4.3	9.9
Counselor	1.5	2.2	0.6	1.9	3.2	0.4	1.0	1.3	0.4	2.2
Disability manager/coordinator	17.3	18.9	16.3	17.4	20.1	17.8	13.9	19.5	16.8	17.2
Parent-involvement manager/coordinator	7.1	10.5	2.4	7.7	12.1	5.6	3.5	10.9	4.6	7.8
Behavioral/mental health manager/coordinator	19.0	20.3	20.3	17.5	20.1	19.3	17.7	28.5	19.2	16.4
Nutrition manager/coordinator	54.0	42.5	57.6	54.6	49.4	60.7	51.1	50.4	56.6	52.9
Culinary or food services staff	9.2	6.4	12.0	8.9	9.4	9.5	8.7	9.3	10.2	8.5
Receptionist/office staff	5.3	12.6	5.3	2.9	8.1	5.1	2.7	10.9	3.9	4.8
Bus driver or related transportation	3.9	4.8	6.3	1.9	5.7	4.0	2.0	10.2	3.7	2.6
Director, associate director, or other program manager	11.0	14.6	6.0	12.2	14.7	9.2	8.9	13.9	8.7	11.6
If other roles, share of time for health services area										
Mean (%)	68.6	54.1	73.1	70.8	60.3	71.9	73.8	60.7	67.7	71.1
Median (%)	75.0	50.0	80.0	75.0	65.0	75.0	75.0	60.0	75.0	75.0
Percentage distribution (%)										
Up to 30 percent	14.2	26.1	8.9	13.0	21.3	11.8	9.3	18.7	11.3	15.0
31 to 50 percent	21.7	28.3	16.1	22.0	25.0	19.8	20.0	29.2	21.0	20.3
51 to 70 percent	11.7	8.8	9.6	14.2	7.7	11.9	16.2	10.5	12.6	11.5
71 to 80 percent	19.8	18.4	23.1	19.1	20.4	20.3	18.9	13.7	23.1	19.3
81 to 90 percent	15.4	9.8	19.4	15.7	12.5	18.1	15.3	11.4	15.5	16.4
91 to 99 percent	6.7	5.4	13.2	4.6	4.8	7.9	7.7	5.1	7.1	6.9
100 percent	10.3	3.1	9.8	11.3	8.4	10.3	12.5	11.4	9.5	10.7
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.4.6. Language and Cultural Competencies of HS/EHS Staff: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Languages spoken and understood by HS/EHS staff (% distribution)										
All primary languages of children and families	53.1	65.1	49.4	50.6	61.6	52.0	45.9	76.6	53.9	47.6
Some primary languages of children and families	46.7	34.9	50.2	49.3	38.3	47.8	54.0	23.4	45.8	52.2
No primary languages of children and families	0.2	0.0	0.3	0.1	0.1	0.2	0.1	0.0	0.2	0.2
Program has teachers, staff members, or consultants who provide guidance on ethnic customs, culture, traditions, and values that may relate to the health, behavioral health, and oral health of the children and families in the program (% distribution)										
Yes	79.3	78.4	81.4	78.8	79.4	77.3	81.1	79.7	76.3	81.0
No	15.1	16.0	14.4	15.6	15.6	16.1	13.7	16.2	16.4	14.1
Don't know	5.6	5.6	4.2	5.6	5.0	6.7	5.1	4.0	7.3	4.8
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.4.10. Health Manager Connections with Other Health Managers: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Number of times connected with other health managers in past year (% distribution)										
No connections	16.4	18.3	17.4	14.2	19.5	17.4	12.4	27.9	15.4	14.7
1 to 2 times	39.0	37.6	37.0	40.6	39.5	35.3	42.4	41.8	40.3	37.8
3 to 6 times	29.7	33.4	28.4	30.2	27.0	33.2	28.9	21.3	29.1	31.7
7 or more times	14.9	10.7	17.2	15.0	14.0	14.1	16.4	9.0	15.2	15.8
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.5.1 HSAC Structure: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Number of HSACs managed (% distribution)										
1	72.9	76.5	70.2	73.2	76.4	75.2	67.6	85.9	73.9	69.7
2 or more	27.1	23.5	29.8	26.8	23.6	24.8	32.4	14.1	26.1	30.3
HSAC shared with another program (% distribution)										
No	83.6	84.3	88.6	81.1	81.4	85.7	83.9	92.9	88.3	78.7
Yes	16.4	15.7	11.4	18.9	18.6	14.3	16.1	7.1	11.7	21.3
If HSAC is shared, type of program (%, more than one may apply)										
With EHS program	64.8	56.1	62.6	68.3	54.1	71.3	72.4	38.8	66.1	66.0
With HS program	73.8	72.5	79.5	74.0	80.9	76.4	64.6	49.4	60.7	79.8
With MSHS program	10.1	12.1	10.0	10.3	3.9	7.6	16.4	31.5	25.6	3.5
With AIAN program	3.1	5.6	3.7	1.7	4.6	4.9	0.0	15.7	2.1	2.6
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.5.2. HSAC Size: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Number of HSAC members										
Mean number	19.7	17.9	19.0	20.2	16.8	19.5	22.7	14.2	20.0	20.7
Median number	15.0	15.0	16.0	15.0	15.0	16.0	20.0	12.0	17.0	16.0
Percentage distribution (%)										
Up to 10	26.0	27.1	27.2	23.9	36.3	24.3	18.3	41.7	22.6	25.0
11 to 15	24.6	25.9	21.1	26.4	26.9	25.1	21.9	32.1	24.4	23.3
16 to 20	18.0	21.2	17.2	17.9	15.0	20.3	18.7	10.7	20.4	18.0
21 to 25	12.3	11.8	13.3	12.0	8.6	12.7	15.5	7.8	13.3	12.6
26 or more	19.1	14.0	21.1	19.8	13.2	17.6	25.7	7.7	19.3	21.1
Number of active HSAC members										
Mean number	12.9	12.5	12.7	12.6	11.4	12.5	14.5	9.7	13.0	13.4
Median number	10.0	10.0	10.0	10.0	10.0	10.0	12.0	8.0	10.0	10.0
Percentage distribution (%)										
Up to 10	53.3	53.9	50.8	53.6	62.9	52.7	44.7	71.0	51.3	51.0
11 to 15	22.0	22.0	23.6	22.1	19.1	24.1	22.7	19.7	22.4	22.2
16 to 20	13.5	14.3	15.3	12.2	11.0	12.4	17.0	5.2	14.0	14.9
21 to 25	5.8	3.6	6.5	6.4	3.0	5.7	8.7	2.8	7.1	5.7
26 or more	5.4	6.1	3.8	5.6	3.9	5.0	6.9	1.4	5.2	6.3
Share of members that are active										
Mean percentage (%)	70.0	73.0	68.3	69.7	72.5	68.6	69.2	70.6	66.6	72.0
Median percentage (%)	66.7	68.2	68.2	66.7	70.0	66.7	66.7	70.0	66.7	66.7
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.5.3. HSAC Member Composition: By Subgroups

Measure	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Groups represented (%)										
HS/EHS program staff										
Program administrators	87.2	87.1	85.2	88.1	86.1	88.1	87.6	87.8	87.4	86.8
Family service workers	60.8	57.1	61.6	61.5	62.2	61.0	59.2	60.3	61.4	60.7
Teachers, teachers' aides, or other classroom staff	28.7	26.2	35.1	26.6	30.3	29.9	25.9	34.8	28.7	27.7
Nutritionists, nutrition experts	80.5	72.1	81.9	81.7	74.5	81.5	85.5	72.3	79.7	82.6
Mental health	73.6	69.7	73.7	74.7	71.3	71.1	78.3	71.4	76.4	72.3
Health educators	68.0	59.7	72.2	68.3	64.6	70.5	69.1	68.1	67.7	68.2
Other HS/EHS staff	24.5	24.1	23.7	25.6	19.2	26.0	28.4	14.1	23.3	27.5
Community members										
HS/EHS staff from another program	22.8	19.6	20.2	25.0	22.6	21.8	24.2	8.6	16.1	29.8
Parents/guardians	87.9	89.9	89.3	87.9	84.3	89.4	89.6	79.5	90.0	88.3
Medical care providers	90.2	91.2	91.8	89.5	88.8	91.3	90.7	92.0	89.6	90.4
Oral health care providers	82.8	79.3	86.4	81.8	78.0	83.1	87.1	86.0	82.0	82.7
Behavioral health providers	59.5	66.5	62.2	57.1	56.1	57.9	64.7	65.0	64.2	55.6
Disability specialists	50.0	47.2	52.3	50.4	46.7	48.4	54.8	45.8	52.9	49.2
Migrant health services	6.2	5.6	5.0	6.6	4.2	5.1	8.4	5.7	7.0	5.9
IHS	8.2	14.7	8.9	6.1	14.2	7.9	2.9	36.9	7.3	2.9
Cultural/community healer	1.8	2.3	1.0	2.1	1.4	2.0	1.9	4.0	0.9	1.8
Public health departments/ boards of health	75.7	69.7	80.1	75.6	66.4	77.4	82.7	62.3	84.2	73.1
WIC or other community food or nutrition service	71.4	64.1	76.8	71.3	66.1	73.3	74.4	65.5	73.2	71.5
Part B and C partners	19.8	19.3	16.4	22.3	20.8	18.0	20.9	17.2	21.0	19.6
School district LEA	35.8	37.5	38.2	34.6	31.7	36.7	38.8	31.9	42.1	32.7
Cultural liaisons	2.7	2.2	3.1	2.8	3.9	3.0	1.3	9.4	2.8	1.4
Advocacy groups	19.5	17.1	18.1	21.2	16.0	18.9	23.7	7.9	17.2	23.3
Other social services providers	40.9	35.8	43.7	41.9	37.5	40.6	44.7	31.7	40.5	43.2
Other local government agencies or officials	20.5	17.7	23.6	20.2	17.0	19.6	24.9	17.9	20.2	21.2
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. Abbreviation: HM = health manager.

Table H.5.4. HSAC Consultation: By Subgroups

Measure	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Frequency of HSAC meetings (% distribution)										
Never (do not formally meet)	0.6	1.6	0.7	0.4	1.3	0.2	0.4	1.0	0.3	0.7
Once a year	7.9	7.4	11.1	7.1	8.9	8.0	6.9	9.1	9.5	6.7
Twice a year	57.4	51.5	62.7	55.8	56.4	60.1	55.7	54.2	62.1	55.3
Every two to five months	31.6	34.0	24.6	34.6	29.6	29.5	35.7	25.8	25.9	36.3
Every month or more	2.4	5.6	0.8	2.2	3.9	2.1	1.3	10.0	2.2	1.1
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.6.1. Program Reports of Major Health Concerns for Children in HS/EHS: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Percentage of programs reporting each health condition as a major concern (%)										
Physical health										
Overweight and obesity (BMI above the 85th percentile)	85.7	86.2	86.5	85.2	78.9	87.6	90.0	84.9	88.9	83.8
Tooth decay or cavities	84.3	82.7	85.3	84.2	83.0	82.6	87.4	87.6	88.0	81.5
Asthma or other lung disease	82.7	75.6	81.0	85.1	77.2	82.9	87.5	71.2	82.2	85.3
Vision conditions	30.3	30.3	32.9	29.5	29.6	31.6	29.4	30.3	30.8	30.1
Ear infections	30.1	29.8	31.6	29.7	32.8	33.2	24.4	37.3	30.9	28.3
Anemia (e.g., sickle cell, low iron)	24.8	25.1	21.5	26.3	24.7	23.8	26.1	20.0	18.8	29.5
Hearing conditions	23.2	26.3	21.6	23.3	25.1	23.9	20.5	20.1	22.2	24.4
Underweight or stunting or failure to thrive	19.6	17.5	19.0	20.4	19.7	19.5	19.5	15.1	16.7	22.3
Diabetes	13.3	11.9	12.7	13.7	13.1	11.7	15.3	18.9	12.9	12.6
Other health problem	9.8	5.4	8.0	11.9	9.2	8.4	11.6	8.5	9.0	10.5
Lead poisoning	9.8	9.0	8.4	11.0	9.7	9.3	10.5	4.2	8.8	11.4
Infectious diseases (e.g., HIV, TB)	3.9	2.3	3.0	4.5	2.8	4.0	4.1	3.9	4.6	3.5
Behavioral health										
Developmental delays (including language delays)	80.3	81.6	80.4	80.5	79.5	82.0	79.4	79.9	79.7	80.8
ADHD or ADD	47.2	39.4	53.8	46.8	40.0	49.8	51.8	48.2	55.3	42.2
Autism spectrum disorders	42.6	38.3	40.0	45.6	38.9	41.4	47.4	32.7	46.0	42.5
Child neglect or abuse	41.1	42.1	38.0	42.7	42.1	41.0	40.2	46.7	42.2	39.2
Family violence	36.2	29.9	33.2	38.7	34.6	37.1	36.8	36.9	35.0	36.8
Anxiety (including OCD)	19.0	14.7	17.9	20.5	18.4	20.9	17.8	21.2	20.6	17.7
Depression	15.8	12.9	13.9	17.8	17.8	15.7	14.0	17.4	16.6	14.9
Other behavioral health problem	10.5	10.8	8.1	11.6	11.3	8.7	11.4	8.8	11.7	10.0
PTSD	8.2	5.2	6.6	9.8	7.0	9.4	8.0	7.0	8.8	8.0
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Response categories have been reordered from highest to lowest prevalence among all HS/EHS programs. Results are weighted to account for survey nonresponse. Percentages distributions are computed for nonmissing cases. HM = health manager.

Table H.6.5. Program Reported Health Concerns for Adult Family Members of Children in HS/EHS: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Percentage of programs reporting each health condition as a major concern (%)										
Overweight and obesity	81.9	78.9	79.2	83.6	76.5	84.0	84.9	84.7	85.1	79.3
Smoking	67.5	61.5	70.4	67.9	65.2	70.0	66.9	71.7	75.6	61.8
Low health literacy	63.8	56.2	58.4	67.8	60.6	65.0	65.6	53.9	64.7	65.3
Alcohol	51.3	49.1	53.6	51.0	52.6	52.9	48.0	68.6	57.5	44.1
Depression	50.2	45.4	49.2	52.2	49.5	54.6	46.4	44.3	51.3	50.7
Family violence	49.8	46.8	46.3	51.8	50.2	50.8	48.3	51.1	49.6	49.7
Illegal substance/drug dependence	40.7	37.5	45.2	40.1	40.7	45.0	36.4	53.8	46.8	34.2
Diabetes	39.0	38.2	33.8	41.0	36.7	38.3	41.9	52.5	37.3	37.4
Asthma or other lung disease	35.1	27.5	31.7	38.8	33.2	33.3	39.0	34.4	30.6	38.1
Anxiety (including OCD)	31.3	20.7	32.6	33.1	30.9	35.0	28.1	26.8	32.2	31.8
Prescription drug dependence	24.8	28.3	29.1	22.5	28.0	27.6	19.1	43.4	29.1	18.6
PTSD	11.5	8.4	8.9	13.7	12.2	10.9	11.5	11.0	11.7	11.5
Infectious diseases (e.g., HIV, TB)	6.9	3.3	6.6	7.9	6.0	6.3	7.5	8.6	6.6	6.7
Other adult health problem	4.8	2.6	5.7	5.2	4.4	5.0	5.2	4.5	4.8	5.0
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Response categories have been reordered from highest to lowest prevalence among all HS/EHS programs. Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.7.1. Approach for Obtaining and Tracking Child Health Information: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Does program have a process for getting and tracking health information for each child? (% distribution)										
No	0.1	0.0	0.3	0.1	0.5	0.0	0.0	0.4	0.1	0.1
Yes, use electronic tracking system	88.5	88.2	88.0	88.9	84.4	90.7	90.3	82.7	88.7	89.6
Yes, use paper/file system	11.3	11.8	11.6	11.0	15.2	9.3	9.7	16.9	11.2	10.3
Source for child health information input into health record (%)										
Written record from health providers	98.5	98.3	98.7	98.5	98.1	98.8	98.7	98.0	98.9	98.4
Interview/oral history from parent/guardian	85.6	82.1	85.0	86.3	84.1	85.7	87.5	82.3	86.9	85.5
Written history from parent/guardian	75.3	80.6	79.5	71.6	72.1	76.2	77.6	81.9	79.9	71.0
Immunization record	96.8	97.7	97.9	96.1	96.6	97.0	97.0	98.0	97.6	96.1
Written record from teacher	43.7	48.1	44.1	41.8	37.4	44.0	49.5	49.6	49.3	38.9
Written note from home visit	55.7	53.6	56.1	55.7	51.7	58.5	57.0	61.8	59.0	52.2
Child health file from previous child care program	47.4	49.8	46.3	47.4	45.1	46.7	50.3	57.2	50.4	43.7
Other	7.3	7.2	4.9	8.1	7.8	5.8	8.3	9.3	6.1	7.5
How often are child health records updated? (%)										
Once a year	16.0	15.4	20.5	14.2	15.0	15.2	17.9	12.0	16.1	16.8
Twice a year	4.4	8.1	3.4	4.0	4.9	4.7	3.8	4.4	4.8	4.2
More than twice a year	22.7	19.6	23.5	23.5	24.9	22.0	21.3	22.9	20.7	23.8
If/when changes to the child's health occur	87.2	85.6	89.5	86.3	86.1	86.7	88.8	88.7	90.4	84.9
Don't update the health record	0.2	0.0	0.4	0.2	0.0	0.4	0.3	0.0	0.0	0.4
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.7.2. Approach to Communication with Parents About Child Health: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Frequency of communication with parents/guardians about child's health and developmental status (% distribution)										
Once a year	1.6	1.2	0.8	1.7	1.4	1.7	1.8	2.5	1.1	1.7
Twice a year	5.9	4.8	4.0	6.4	5.4	5.9	6.4	4.3	4.4	7.0
Every two to five months	16.1	17.4	14.2	16.7	19.2	14.9	14.5	20.6	14.2	16.4
Every month	23.0	26.0	25.7	20.9	20.4	22.2	26.3	17.7	25.2	22.5
Several times a month	23.8	27.0	20.0	25.1	24.0	23.5	23.6	24.8	24.0	23.4
Weekly	16.5	10.6	17.4	17.8	17.7	18.3	13.6	16.0	15.8	17.1
Other	13.2	13.0	17.8	11.3	12.0	13.4	13.9	14.1	15.3	11.9
Most common method used to share information with parents/guardians about child's health (% distribution)										
Formal meetings	6.0	5.2	4.2	6.9	7.4	3.9	6.4	4.8	6.1	6.2
Phone calls	23.0	23.9	23.6	23.0	20.2	24.1	24.5	25.5	26.4	20.4
Email/electronic communication	0.3	0.9	0.5	0.2	0.3	0.3	0.5	0.8	0.2	0.3
Written communication	31.0	31.9	33.0	30.0	30.5	30.0	32.7	36.4	31.3	29.6
In-person communication at drop-off or pick-up	28.7	27.7	27.2	29.6	29.7	28.9	27.8	24.5	25.7	31.4
Other	11.0	10.4	11.4	10.4	11.9	12.9	8.2	8.0	10.4	12.1
Frequency of meeting with parents/guardians (phone or in person) to discuss health management of a child with special health care needs (% distribution)										
Never	1.2	1.7	0.3	1.5	1.3	1.3	0.9	0.0	0.9	1.6
Once a year	5.1	3.5	5.4	4.7	3.2	7.2	4.7	3.9	6.7	4.3
Twice a year	11.1	8.1	11.9	11.6	11.4	11.3	10.6	10.8	12.7	9.9
Every two to five months	20.7	19.5	17.5	22.1	22.0	18.1	22.0	21.1	18.5	21.9
Every month	22.1	24.8	23.5	21.0	22.9	21.3	21.8	21.8	22.4	21.8
Several times a month	19.4	16.3	20.3	20.1	19.0	19.9	19.0	19.9	16.1	21.2
Other	20.4	25.5	20.9	18.6	19.3	20.8	20.8	21.7	22.4	18.8
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.8.5. Types of Medical Care That Providers Deliver On-site at the HS/EHS Program: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Types of medical care providers come to HS/EHS program to provide on-site (%)										
Physical exams	19.2	18.4	18.2	19.7	16.2	16.4	24.5	21.0	20.0	18.3
Immunizations	14.6	8.9	15.6	15.1	15.8	13.1	14.6	17.7	14.1	14.2
Oral health prevention	60.1	55.3	64.0	60.0	62.2	55.1	62.8	67.8	57.1	60.3
Oral health treatment	35.1	28.4	37.5	35.8	31.0	33.0	40.6	29.4	34.5	36.4
Behavioral or mental health care	66.3	65.7	68.7	65.5	66.2	66.2	67.0	68.0	67.8	65.2
Care or therapy for individuals with disabilities	63.1	61.6	71.3	59.2	63.1	64.0	62.5	66.2	69.7	58.5
Nutritional care	25.8	28.0	19.5	27.4	24.8	26.1	26.2	19.5	23.3	28.6
Physical therapy	50.6	45.8	56.2	49.4	51.9	52.0	48.1	50.0	55.1	47.9
Speech therapy	82.1	84.7	87.0	79.8	81.1	82.0	83.7	89.3	87.9	77.3
Laboratory services	10.2	8.8	11.3	10.0	8.9	8.9	12.9	8.1	12.1	9.5
General health education	53.2	45.7	54.9	54.5	48.4	56.6	54.0	50.9	50.7	55.3
No medical, oral, or behavioral care is provided at the program	3.7	4.2	1.9	4.1	4.0	4.0	3.1	2.4	2.3	4.9
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.8.6. Processes Used to Ensure Children Receive Follow-Up Health Services: By Subgroups

Measure	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Processes used to ensure children received follow-up services for physical, behavioral, and oral health (%)										
Conduct a periodic review of child health files to ensure that follow-up service were received	94.2	93.0	95.3	93.8	93.2	94.1	95.2	87.5	95.1	95.0
Follow up with health care providers to obtain copy of health service record	86.9	83.0	91.7	85.6	84.9	87.8	88.2	83.3	92.0	84.5
Follow up with parents/guardians to ensure that services were received	94.9	95.3	96.2	94.3	94.9	95.5	94.6	94.0	95.1	95.0
Discuss with health staff at regular program meetings	66.6	61.9	63.0	69.1	60.9	65.8	73.0	58.3	65.7	68.9
Follow up with classroom teachers	67.4	69.1	69.7	66.5	65.0	68.4	68.9	68.0	71.2	65.0
Use an external evaluator to review health records	12.9	9.0	13.8	13.4	13.8	12.2	12.9	11.5	10.8	14.5
Other	9.2	6.9	10.1	8.9	9.0	9.8	8.8	8.7	7.9	10.1
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. Abbreviation: HM = health manager.

Table H.8.7. Health Services or Health Programs Offered in Home: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Program provides health services or health programs in the home (% distribution)										
Yes	42.0	33.9	40.7	44.6	40.3	44.6	40.5	28.3	46.2	42.2
No	55.3	63.7	56.7	52.5	55.3	53.4	58.0	69.0	51.4	55.1
Don't know	2.7	2.4	2.6	2.9	4.4	2.0	1.5	2.6	2.4	2.7
Among programs offering services in the home, which services are conducted in the home? (%)										
Conduct health screenings	60.4	51.3	63.6	61.1	58.7	60.1	63.4	49.8	57.4	63.9
Provide immunizations	0.9	2.1	0.9	0.7	1.1	1.5	0.0	6.9	0.0	0.7
Attend to the physical health needs of children with chronic health issues	19.7	14.6	21.5	19.9	18.3	18.6	22.9	18.2	18.3	20.9
Teach children about healthy behaviors	76.1	78.0	78.7	74.1	78.4	76.6	74.2	70.5	79.8	74.9
Teach parents/families about supporting healthy behaviors	88.7	84.2	87.9	90.0	87.3	89.6	89.2	82.6	89.7	89.1
Provide counseling or other mental health services	41.9	35.0	37.6	44.3	39.8	44.5	40.9	39.2	39.8	43.8
Provide nutritional services	61.4	52.0	64.5	61.6	61.2	61.2	62.4	50.0	61.4	63.3
Help families enroll in health insurance	76.6	63.8	81.7	76.9	75.3	78.4	76.2	69.6	83.0	73.7
Other	13.4	5.3	13.1	15.0	17.2	11.5	11.7	22.9	13.8	11.6

Table H.8.7. Health Services or Health Programs Offered in Home: By Subgroups, *Continued*

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Among programs offering services in the home, what barriers are faced when providing health services or programs in the home? (%)										
Cultural or religious beliefs or barriers	24.2	19.3	17.8	27.4	20.9	20.9	31.8	8.4	23.9	26.7
Language barriers between HS/EHS staff and families	27.7	13.2	25.5	31.6	22.9	29.1	31.9	12.3	25.0	31.7
Literacy barriers	44.4	33.0	46.9	46.0	43.2	46.5	43.5	27.7	47.2	45.0
Parent/guardian lack of time	57.9	70.7	60.2	55.5	54.0	58.5	60.7	64.4	66.2	51.7
Parent/guardian does not understand importance of screening/treatment	73.4	72.2	74.9	73.3	70.8	75.2	74.4	63.9	78.7	71.4
Parent/guardian resistance to treatment	55.5	52.6	58.8	55.3	48.3	58.5	60.2	52.1	60.1	53.0
No physical space to conduct activities in the home	17.8	17.6	18.1	18.2	16.9	17.9	18.3	8.1	20.2	17.6
Difficulty finding a quiet space to conduct activities without interruption	30.6	34.5	32.3	29.5	31.0	33.6	26.9	12.3	35.0	30.0
Privacy concerns to discuss health-related matters in the home	16.0	21.0	13.3	16.7	16.9	17.3	14.0	11.0	15.0	17.4
Discomfort with staff in being in the home	18.0	16.5	19.3	18.3	23.5	16.6	14.9	24.5	18.7	16.6
Safety issues for staff to be in the home	24.9	27.0	19.9	26.2	20.0	24.6	30.5	15.0	26.8	24.7
Other	6.5	5.5	7.8	5.8	9.3	5.9	3.9	14.0	4.7	6.3
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.8.8. Other Health-Related Services Offered to Families by HS/EHS Programs: By Subgroups

Measure	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Percentage of programs offering service to families (%)										
Health-related events for the entire family, including health services for other family members	68.2	65.0	69.9	68.1	66.5	67.4	70.8	69.3	63.3	71.3
Weight-management program or education	53.9	53.2	55.8	53.2	50.8	54.6	56.4	47.7	53.6	55.5
Smoking cessation	35.6	34.1	42.0	33.0	30.9	40.7	34.9	36.2	42.3	31.4
Information about health insurance and assistance enrolling	90.9	90.2	92.0	90.7	87.6	92.5	92.3	87.7	95.0	88.9
Workshops or education on parenting (e.g., classes on child development, education in being a parent, understanding children with special needs)	87.4	89.2	87.0	87.3	88.3	86.7	87.6	85.8	88.1	87.4
Adult literacy or health program (including Adult Basic Education)	53.3	60.8	57.8	49.6	48.8	53.6	57.7	47.7	55.5	53.2
Health literacy	65.3	67.9	68.2	63.5	63.8	66.0	66.3	66.1	68.2	63.5
Health or social services offered collaboratively by service agencies, such as hospitals	67.4	64.3	70.1	66.8	65.1	69.2	68.1	57.0	69.0	68.6
Other	28.2	28.6	37.3	24.4	27.4	26.0	31.9	39.7	34.6	23.3
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.8.9. Services Offered to Pregnant Women by EHS Programs: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Program offers services to pregnant women (% distribution)										
Yes	93.9	98.8	90.9	94.1	91.9	95.8	100.0	92.5	96.4	93.2
No	4.9	1.2	7.1	4.7	6.5	3.2	0.0	7.5	3.6	5.0
Don't know	1.2	0.0	1.9	1.2	1.6	1.0	0.0	0.0	0.0	1.8
Among programs offering services to pregnant women, percentage of programs offering service (%)										
A referral to an OB, nurse/midwife, or other provider for pregnant women	87.2	75.9	79.4	85.6	86.5	88.5	85.1	81.6	90.0	87.0
A referral to a dentist for the mother	94.1	80.7	84.7	89.3	92.9	94.8	98.2	94.1	95.7	93.5
A referral to a pregnancy or childbirth class	84.9	97.2	91.6	94.4	83.5	87.5	81.7	76.4	88.1	84.8
A referral for a doula (or someone to help with the birthing process)	39.3	78.0	84.7	86.3	38.4	39.3	44.6	41.7	38.2	39.5
Information on how to take care of themselves during pregnancy	98.4	32.8	40.3	40.3	98.1	98.4	100.0	100.0	98.8	98.1
The chance to get together with other pregnant women or mothers	78.1	98.4	96.1	99.2	77.7	78.5	79.3	82.8	77.0	78.0
Nutrition information	98.6	76.6	75.9	79.0	98.5	98.5	100.0	100.0	98.8	98.4
Classes for new or expectant fathers	39.2	98.9	96.9	99.2	37.5	42.3	36.1	38.9	46.7	36.5
Information on how to prepare their homes for a new baby	93.7	34.9	43.7	38.6	93.2	94.5	92.9	88.9	93.4	94.4
Help finding clothes, a stroller, or other baby care items	93.2	95.0	91.7	94.1	92.6	94.0	93.1	87.9	94.6	93.6
Information on how to take care of babies	97.7	93.2	90.1	94.3	97.4	98.0	98.5	96.1	97.8	97.9
Information on breast-feeding	97.9	98.4	95.4	98.4	97.1	98.6	100.0	96.6	98.3	97.9
A referral to someone to help with breast-feeding (lactation consultant)	86.2	97.2	96.1	98.7	86.2	86.4	85.3	78.0	89.5	86.0

Table H.8.9. Services Offered to Pregnant Women by EHS Programs: By Subgroups, *Continued*

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
A referral for smoking cessation	79.7	72.4	77.4	81.9	77.0	83.4	82.1	77.8	84.0	78.7
Referrals for drug and alcohol cessation	84.2	77.4	80.8	86.6	80.8	88.2	87.7	76.8	88.5	83.7
Postpartum services, including information on postpartum depression	96.5	96.4	93.9	97.4	95.0	98.0	100.0	92.2	98.1	96.4
A referral to a pediatrician for the baby	87.1	85.7	87.0	87.4	86.3	90.1	80.1	74.5	91.9	86.9
Information on how children grow and develop	97.8	97.2	95.5	98.8	97.4	97.8	100.0	95.7	98.8	97.7
Parenting classes	73.0	74.5	66.5	75.2	72.8	73.7	70.6	72.7	67.0	75.1
Sibling classes	21.6	19.3	26.3	20.5	19.9	24.3	18.6	19.1	18.9	22.9
Other	11.4	5.1	12.1	12.5	9.0	15.9	6.2	5.4	11.2	12.3
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.9.3. Ability of Partnerships to Address Physical Health Needs of Children: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Describe ability of partnerships to handle physical health needs of children in the program (% distribution)										
Not adequate	0.7	0.0	0.3	1.1	1.1	0.5	0.6	2.1	0.7	0.5
Somewhat adequate	12.4	13.3	10.9	13.0	13.7	11.0	12.6	11.3	11.1	13.5
Adequate	41.0	36.3	42.1	41.7	41.0	42.8	39.7	39.5	40.8	41.6
Very adequate	45.2	50.0	46.3	43.3	44.1	44.5	46.4	47.1	46.7	43.6
Not applicable	0.7	0.4	0.4	0.9	0.2	1.2	0.7	0.0	0.7	0.9
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.9.4. Ability of Partnerships to Address Physical Needs of Disabled Children: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Describe ability of partnerships to handle needs of children with disabilities in the program (% distribution)										
Not adequate	1.2	0.0	0.9	1.6	1.6	1.0	1.0	2.9	1.1	0.9
Somewhat adequate	14.6	13.0	13.1	15.9	13.2	14.9	15.7	19.9	13.7	14.2
Adequate	42.3	45.5	43.5	40.7	43.2	43.4	40.4	41.0	41.6	43.0
Very adequate	40.9	41.5	42.2	40.2	40.7	39.4	42.5	36.3	42.7	40.6
Not applicable	1.0	0.0	0.3	1.6	1.4	1.3	0.3	0.0	0.8	1.3
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.10.3. Ability of Partnerships to Address Behavioral and Mental Health Needs of Children: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Describe ability of partnerships to handle behavioral or mental health needs of children in the program (% distribution)										
Not adequate	3.7	0.6	2.5	5.1	3.2	4.0	4.1	6.1	4.0	3.1
Somewhat adequate	20.5	19.7	22.8	19.9	20.7	21.6	19.2	21.9	20.4	20.3
Adequate	49.1	48.3	48.9	49.0	48.7	47.6	51.2	44.1	47.6	51.2
Very adequate	26.0	31.3	25.0	25.2	27.4	26.1	24.4	27.9	27.5	24.5
Not applicable	0.7	0.0	0.8	0.8	0.0	0.8	1.2	0.0	0.5	0.9
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding.aHM = health manager.

Table H.11.3. Ability of Partnerships to Address Oral Health Needs of Children: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Describe ability of partnerships to handle oral health needs of children in the program (% distribution)										
Not adequate	4.2	4.0	3.5	4.5	2.4	5.0	5.1	3.0	6.4	3.0
Somewhat adequate	19.4	15.4	19.8	20.6	19.0	20.6	18.5	22.2	20.9	17.9
Adequate	38.2	39.4	39.2	37.1	39.6	38.1	37.2	31.5	38.8	39.2
Very adequate	37.3	40.0	37.3	36.6	38.5	35.3	37.9	43.3	33.2	38.6
Not applicable	0.01	1.2	0.3	1.2	0.5	1.1	1.3	0.0	0.7	1.3
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.12.4. Approaches Used to Find Health Topic Resources or Curricula: By Subgroups

Measure	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
How health managers find possible resources or curricula for a health topic that needs to be addressed (%, more than one may apply)										
Prior use/familiarity with the curriculum	68.5	54.9	70.0	71.4	65.5	71.1	68.6	66.1	69.1	68.6
Recommendation from other HS/EHS programs	50.5	53.3	51.7	49.7	47.8	53.1	50.9	41.1	53.1	50.8
Recommendation from HSAC	70.4	68.8	72.7	70.1	65.4	72.1	73.4	67.9	74.6	68.2
Recommendation from consulting provider or other community partners	73.0	69.3	75.6	73.0	72.3	72.7	74.5	69.9	75.7	72.1
Head Start website	83.3	82.1	86.9	82.4	80.5	84.1	85.5	79.8	86.5	81.9
Technical assistance network for HS/EHS	51.3	50.5	52.5	50.6	49.2	49.1	55.5	52.9	55.8	48.0
Child care health and safety resources	63.4	56.7	64.3	64.4	60.5	66.9	62.8	59.0	66.2	62.5
Professional association websites or listservs	59.5	43.4	60.7	63.3	55.4	61.1	61.6	50.5	62.2	59.4
Recommendation from state or local government	56.8	47.6	56.7	58.9	52.1	57.4	60.2	50.6	57.4	57.4
General Internet search	63.8	68.4	60.3	64.5	62.0	64.0	65.7	64.2	64.6	63.1
Other	6.0	5.0	4.4	6.6	6.5	5.7	5.9	9.1	5.6	5.7
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.12.9. Challenges with Implementing Health Promotion Activities: By Subgroups

Measure	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Biggest challenges to starting health-promotion activities in the program (%)										
Lack of support from the HSAC	3.7	3.0	3.9	3.8	3.8	3.3	3.9	3.5	4.7	3.0
Lack of support from the director	5.3	3.5	4.2	5.9	4.9	5.9	4.8	3.4	4.7	6.0
Lack of staff buy-in	35.8	33.1	33.4	37.5	29.2	36.6	41.2	35.6	37.6	34.8
Not enough time to provide training to staff	42.4	42.7	41.5	42.7	42.9	42.5	42.1	37.6	41.4	44.1
Lack of parent or family interest/support in the topic	57.8	59.7	60.0	56.4	58.3	60.8	54.1	66.2	60.7	54.2
Limited time to implement	47.5	42.3	43.8	50.1	44.6	48.3	49.2	42.8	48.4	48.1
Lack of parent or family time to engage in the activity or the timing of the activity	49.0	50.4	47.2	49.3	47.5	51.8	47.8	46.7	53.2	46.9
Poor quality of the health-promotion curriculum or program to address the health topic	4.5	3.9	3.7	5.1	3.6	4.3	5.5	7.8	4.5	4.0
Poor quality of the health-promotion trainers	2.9	1.8	2.5	3.4	2.6	3.2	2.8	3.4	4.3	2.0
Not having enough staff who speak the languages of the families we serve	6.2	3.8	7.5	6.0	5.1	5.8	7.6	3.7	5.7	7.0
Not having enough staff who come from the cultural backgrounds of the families we serve	3.5	2.0	4.2	3.6	2.6	4.5	3.4	1.5	3.4	4.0
Not having enough health materials in the languages of the families we serve	13.0	11.9	10.3	14.0	14.2	11.6	13.5	10.9	9.1	15.9
Not having enough health materials that are culturally appropriate for all families	12.4	10.5	8.0	14.6	11.9	13.4	12.1	10.9	10.5	13.9
Limited parent literacy	19.4	13.1	18.0	21.5	18.4	19.9	20.2	11.7	16.9	22.5
Competing program priorities/ not enough resources or funds	36.8	32.4	33.3	39.4	34.8	34.3	41.2	33.7	35.3	38.2
Other	6.3	6.0	6.2	6.4	6.6	5.6	6.9	8.1	6.1	6.2
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.13.4. Health Needs Not Being Met by Partner Agencies and Organizations: By Subgroups

Measure	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Health need not being met (or met well) by agencies and organizations program works with (%)										
Health care	11.5	13.9	15.0	9.4	12.4	9.5	12.5	16.7	10.3	11.2
Oral health care	29.3	23.4	29.7	30.4	25.3	30.8	31.2	29.1	33.6	26.7
Behavioral health care	28.0	23.1	29.1	28.7	29.5	29.6	25.1	33.0	26.3	28.2
Services for children with disabilities/medically fragile children	14.1	11.7	13.3	14.9	13.7	13.7	14.8	21.3	11.1	14.5
Asthma management and/or education programs	16.4	15.0	18.6	15.7	18.2	16.3	14.7	22.1	16.4	15.2
Services for weight control	44.0	36.3	46.2	44.9	39.9	46.7	45.1	45.6	45.3	42.9
Hearing or vision services	15.0	11.1	16.2	15.4	17.6	14.3	13.4	19.7	14.3	14.6
Treatment for alcohol or substance use	30.3	30.8	29.5	30.5	32.2	28.5	30.3	33.8	29.1	30.3
Programs for smoking cessation	34.6	38.1	34.2	33.8	36.9	32.0	35.5	36.4	31.1	36.3
Services for pregnant women	17.2	20.4	15.0	17.3	19.2	16.9	16.0	20.8	14.8	18.1
Environmental health concerns	29.1	31.1	27.1	29.6	29.6	30.1	28.1	29.6	28.9	29.0
Injury prevention or safety concerns, emergency management	14.9	21.4	15.2	13.4	15.9	13.8	15.0	19.1	14.7	14.2
Some other health service	8.1	9.4	8.7	7.6	9.1	8.4	6.6	13.5	7.9	7.2
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.
NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.13.5. Health-Related Community Partners Would Like to Work With: By Subgroups

Measure	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
Percentage would like to have a relationship with health-related community partner not working with now (%)										
Social service agency	12.7	12.9	14.4	11.9	14.8	14.1	9.1	9.7	10.7	14.4
Food/nutrition agency	7.8	10.0	7.1	7.6	10.7	6.3	6.4	6.6	5.7	9.2
Home visiting programs	13.5	14.6	14.5	12.7	10.7	13.8	15.8	12.0	10.9	15.4
Local health departments, department of public health	5.6	6.3	4.5	6.0	7.2	6.4	3.3	13.1	4.3	4.9
Migrant community health centers	14.2	13.9	10.4	15.9	12.3	15.4	15.2	13.8	13.8	14.6
IHS	12.6	11.6	11.8	13.2	10.6	12.7	14.6	12.6	12.2	13.0
Tribal organizations	12.3	10.2	12.3	12.7	9.7	12.2	14.8	8.7	13.3	12.4
Safety net dental clinics	17.3	15.1	14.8	18.8	15.5	21.0	15.1	18.5	18.2	16.4
Community health centers and/or local hospitals	12.6	12.5	14.7	11.9	9.6	16.5	11.6	14.8	12.6	12.2
Community behavioral or mental health center	12.9	11.7	12.5	13.4	12.4	14.7	11.5	10.8	11.5	14.0
Migrant education	12.1	11.5	11.9	12.4	10.5	13.2	12.8	11.4	10.7	13.1
College or university	23.6	25.7	27.5	21.5	23.9	25.9	20.9	25.7	26.1	21.6
Religious organization	15.7	17.4	13.6	16.2	14.5	17.7	14.8	15.3	14.9	16.4
Public school/LEA	3.3	2.7	5.7	2.4	4.6	3.9	1.4	6.6	1.2	3.9
Part C and Part B IDEA partners	5.3	6.2	4.8	5.3	4.7	7.0	3.8	5.9	4.4	5.7
Programs to provide family financial planning	26.7	27.4	24.8	27.5	27.0	28.9	24.5	30.6	25.9	26.5
Job service agency	25.8	29.4	23.4	25.9	28.7	26.1	22.7	27.6	20.3	28.5
Legal aid	34.3	40.4	29.5	34.9	35.0	35.4	32.5	42.0	29.8	35.4
Other community agency	8.7	8.2	8.2	9.0	9.3	9.4	7.1	8.2	8.6	8.7
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

Table H.14.3 Budget and Source of Funds Used for Treatment Services: By Subgroups

Measures	Total	By HM Health-Related Education			By Program Size			By Program Rural-Urban Status		
		None	AA	BA	Small	Medium	Large	Rural	Mixed	Urban
A set portion of HS/EHS budget is designate for treatment services for physical, behavioral, or oral health (% distribution)										
Yes	63.4	64.3	65.8	62.5	54.4	64.0	71.5	56.0	74.2	58.3
No	14.1	11.7	11.0	16.2	19.2	12.7	10.3	18.0	9.1	16.5
Don't know	22.5	24.0	23.2	21.3	26.5	23.3	18.1	26.0	16.7	25.2
Sources of funds used to pay for physical, behavioral, or oral health treatment services (%)										
Medicaid, SCHIP, other publicly funded insurance for children	93.2	91.4	93.7	93.4	92.5	92.3	94.7	94.9	95.8	91.1
County indigent funds	8.5	4.3	11.7	8.3	7.6	6.9	10.8	7.9	7.9	8.9
Private insurance	77.4	75.2	81.7	76.2	74.5	80.0	78.0	80.6	85.0	71.8
Family self-pay, out-of-pocket expense	35.0	25.4	37.9	36.2	32.9	35.0	37.0	24.5	37.4	35.4
Grant funding from an external source	16.4	11.5	15.2	18.3	16.2	15.5	17.1	15.0	16.3	16.7
In-kind contributions from providers	51.1	47.2	52.9	50.6	46.4	50.5	55.4	45.5	53.0	50.7
HS/EHS program budget	70.6	68.0	75.2	69.7	64.1	69.9	76.8	63.7	78.9	66.3
Other source	6.4	7.4	6.6	6.0	8.6	5.0	6.0	16.1	4.8	5.7
Number of programs	1,902	236	467	1,068	593	643	656	193	675	1,030

SOURCE: Authors' analysis of the Head Start Health Manager Descriptive Study's Health Manager Survey.

NOTES: Results are weighted to account for survey nonresponse. Percentage distributions are computed for nonmissing cases and might not sum to 100 because of rounding. HM = health manager.

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