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Promoting the Health of Poor Preschool Children:
What Do Federal Head Start Performance Standards Require?

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Head Start is a federal-to-local grant program for the provision of early childhood education, comprehensive services, and family support to more than 900,000 low-income children and their families. Head Start programs must adhere to a set of performance standards regarding what services are to be provided, including health, parental involvement, nutritional, social, and transition to school.[1] This paper describes the specific requirements for the provision of health screenings and services to participating low-income children and their families. The key components of the standards are:

- ✓ Conducting comprehensive health and developmental screenings within a set period after a child enrolls in Head Start;
- ✓ Linking families to ongoing sources of health care when families do not have them;
- ✓ Following up with families to assure they secure further diagnosis and treatment for Head Start children;
- ✓ Tracking all the health care services Head Start children receive; and
- ✓ Individualizing how Head Start programs and staff respond to children's health and developmental needs.

In 2002, more than 200,000 Head Start children were diagnosed as needing follow-up treatment after being screened for medical issues through Head Start. The vast majority of these children subsequently received medical treatment. Identifying medical problems as early as possible can help prevent worsening health conditions that can impair young children's development and preparation for school, and it must be a key component of promoting school readiness for disadvantaged children.

Head Start Program Performance Standards require that children be screened for developmental, sensory, and behavioral concerns within 45 calendar days of enrollment.[2] Screenings are used to identify if any children need more formal assessments of potential health and developmental needs. Enrolled children must receive screenings to identify concerns with developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual, and emotional skills. Programs are to assure that these screening procedures are sensitive to children's cultural backgrounds, to the maximum extent possible. Programs must review any available

information on screenings children may already have received, so as to supplement and not duplicate previous screenings. Head Start programs are not required to use any particular screening tool.

In 2002, 86 percent of Head Start children received medical screenings, and 78 percent received dental exams. These percentages reflect the proportion of all children who spent any time in the program, even those who left the program prior to the 45-day mandate.[3]

Head Start Program Performance Standards require that, within 90 calendar days of child enrollment, programs must determine whether families have an ongoing source of continuous, accessible health care and must assist parents in securing a source of such health care, if necessary.[4] Programs are required to work together with parents to review their children's health and medical needs and to determine whether children have a source of health care. If they do not, programs and parents plan together how to secure health care coverage, so that parents can navigate this process long after their children have left the Head Start program. Head Start funds may only be used for medical and dental services if programs can show that families cannot access other sources of funding. Head Start guidance suggests programs develop partnerships with state, local, and Tribal health departments; public health service programs; Supplemental Nutrition Program for Women, Infant, and Children (WIC) clinics; and the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

In 2002, most Head Start children (87 percent) were enrolled in health insurance plans, most commonly through Medicaid or the EPSDT program (53 percent), private insurance (15 percent), a state Child Health Insurance Program (CHIP) (8 percent), or a combined Medicaid/CHIP program (8 percent).

Head Start Program Performance Standards require that programs work with parents to arrange for any needed follow-up health or developmental diagnostic testing or examinations, as well as any necessary treatment or immunizations for children.[5] Program staff are responsible for working with parents to develop a follow-up plan to assure that problems are treated and addressed and that the children are receiving regular well-child health care. Head Start staff responsible for health follow-up are urged to check regularly with parents on children's identified health needs, to encourage any health care professionals serving Head Start families to explain any procedures to them, and to help parents learn how to navigate health care insurance (such as Medicaid or private, employer-sponsored insurance programs) and delivery systems.

In 2002, 24 percent of Head Start children who were screened for medical problems were assessed as needing treatment, and 89 percent of those children received treatment.

Head Start Program Performance Standards require that programs track the provision of health care services by maintaining individual child health records.[6] Head Start staff must work with parents to make sure that the results of medical and dental exams, as well as any treatment plans and follow-up care received, are recorded in a record system maintained by the program. These records are shared only with

authorized staff and in meetings with parents to assure children are receiving necessary follow-up services and to help tailor Head Start to children's needs.

In 2002, of the 184,981 Head Start children who received medical treatment, 26 percent received treatment for asthma, 22 percent for being overweight, 17 percent for anemia, 14 percent for vision problems, and 11 percent for hearing difficulties.

Head Start Program Performance Standards require that programs individualize their approach to each child based, in part, on the health and developmental information gathered through these processes, as well as through communication with parents.[7] Head Start guidance states that programs should tailor curricula and physical environments to respond to children's learning styles, strengths, and needs.

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[1] 42 USC 9836A Sec. 641A.
[2] Head Start Performance Standards. 45 CFR 1304.20(b)(1)
[3] See Schumacher. R,. & Irish, K. (2003, May). *What's New in 2002? A Snapshot of Head Start Children, Families, Teachers, and Programs.* Washington, DC: Center for Law and Social Policy. All 2002 Head Start data come from this policy brief. CLASP's calculations of the percentages of children who received medical screenings, dental exams, and immunizations or were referred to mental health specialists may slightly under-represent the percentage of children who received these services because there is no way to adjust the figures to exclude those children who dropped out of Head Start within their first 45 calendar days.
[4] Head Start Performance Standards. 45 CFR 1304.20(a)(1)(i)
[5] Head Start Performance Standards. 45 CFR 1304.20(a)(1)(iii) & (iv)
[6] Head Start Performance Standards. 45 CFR 1304.20(a)(1)(ii)(C)
[7] Head Start Performance Standards. 45 CFR 1304.20(f)(1)