

Health in Head Start: Expanding Access and Improving Quality

*National Head Start Association
February 2017*

Executive Summary

Across the country, every Head Start program provides comprehensive health, nutrition, and education services to children and families in poverty. Head Start's comprehensive approach ensures that children have access to health insurance, regular screenings, immunizations, well child visits, dental and nutrition services, streamlined access to necessary medical attention, daily healthy meals, and connections to other social service programs, such as SNAP and WIC. As the original two-generation model, Head Start also provides services to parents, ensuring lasting impacts. In providing these services, local Head Start programs have flexibility in how they meet their particular children and families' unique needs by both harnessing the strengths of their community and helping improve upon any limitations. For example, access to health services varies greatly across the country. In some communities, all families have access to the care they need, while in other communities there are few, if any, providers and long waits for appointments.

In the spring of 2016, the National Head Start Association (NHSA) conducted a nationwide survey of programs to determine the various ways programs are providing health services to their children and families. The key trends that emerged reveal several opportunities for improvement and additional support. According to the survey, health providers frequently do not conduct children's screenings properly or provide adequate feedback, and there is a significant communication gap between health providers, families, and program staff. Many programs pay for screenings and associated medical service costs, such as transportation and interpretation, with program funds. Some programs have found innovative ways to provide improved services, from partnering with local Medicaid providers to hosting community health fairs before the school year begins.

Based on survey findings, NHSA makes recommendations in three areas:

- (1) At both the federal and state level, the collaboration between Head Start and Medicaid agencies should be strengthened to enable programs to bill Medicaid for medical services.
- (2) Collaboration with other local agencies can improve access to health services, the accuracy of screenings, and the quality of care for Head Start children and families.
- (3) The Head Start community needs a system for sharing the innovative solutions and best practices that are currently being developed in isolation across the country.

Health in Head Start

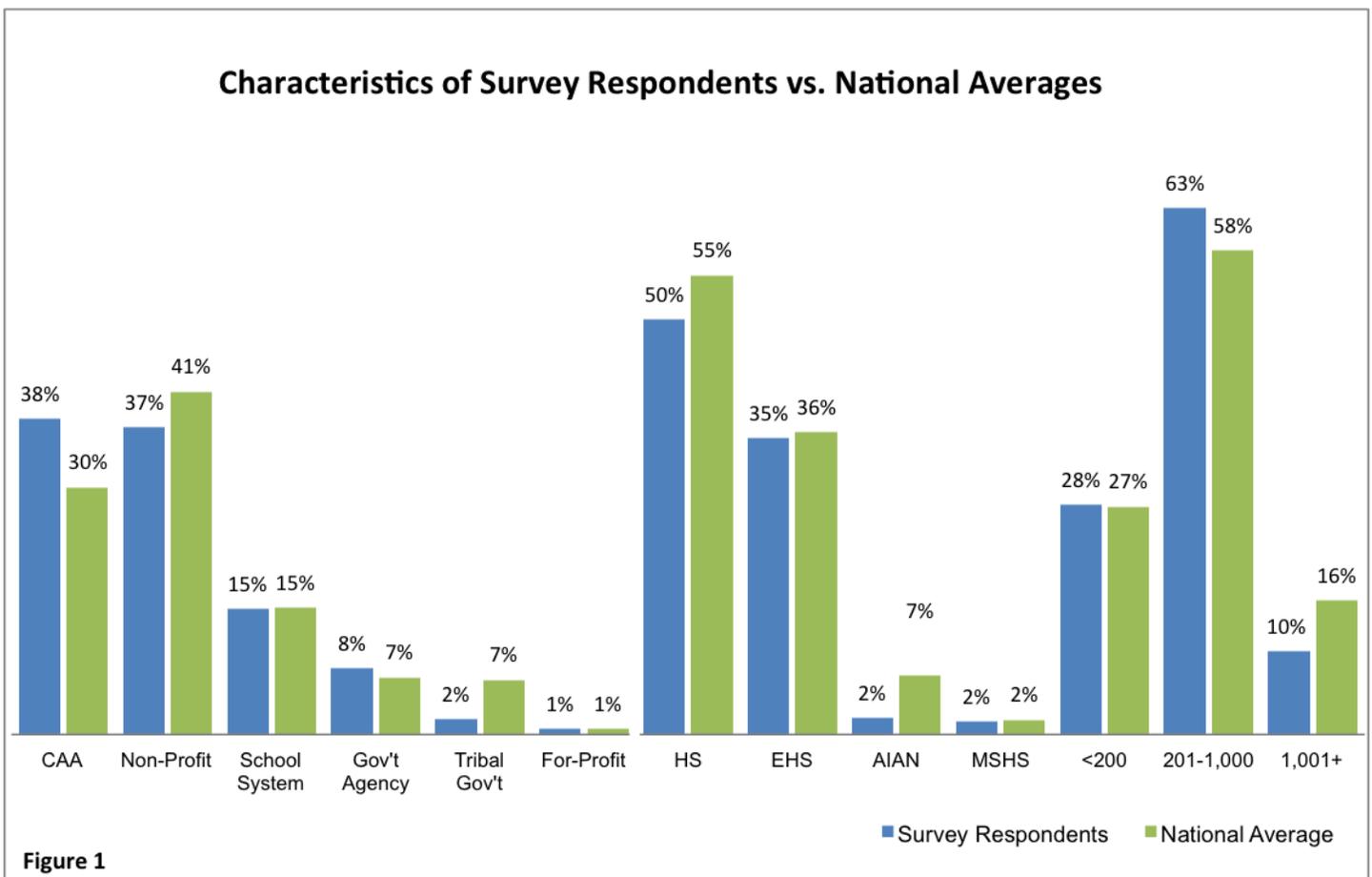
From its earliest days, children's health has been a core component of the Head Start model. From Head Start's initial implementation, Dr. Robert Cooke and a team of psychologists wrote that the first objective of the program was "improving the child's physical health and physical abilities." At the time, there were areas of the country where children in poverty often did not receive necessary immunizations, let alone see a doctor or dentist regularly. The provision of these services to children about to begin school was one of the first triumphs of the new program.

For more than fifty years, Head Start has integrated health care access, immunizations, screenings, and developmental supports into the comprehensive services offered to children and families. Poverty too often goes hand in hand with poor health and limited access to necessary medical services. Without access to doctors for routine check-ups and specialists to identify and treat disabilities or delays, some children suffer unnecessarily for years during a critical period of development, ultimately undermining their full potential. Head Start's comprehensive health services address these needs and are integral to the success of children and families.

Today, health remains an essential and unique part of Head Start. The Head Start Program Performance Standards codify expectations that programs help each family establish a source of continuous, accessible health care for their children's medical, dental, and mental health needs and ensure that children receive immunizations and well child visits. Programs must obtain or perform vision and hearing screenings for each child within 45 days of entry into Head Start. If any issues are identified, whether a need for glasses or a developmental delay, appropriate follow-up and treatment is required. As is reflected in the Standards and in practice, Head Start is committed to the idea that children must be healthy to learn and that health services, especially early in life, are essential to supporting children's readiness for success in school and beyond.

In April 2016, the National Head Start Association conducted a voluntary survey of Head Start programs asking about access to medical, dental, mental, and other health services in their communities. A total of 482 Head Start programs participated in the survey, approximately one quarter of Head Start and Early Head Start grantee and delegate agencies nationwide. While participation was voluntary, the programs that responded closely reflect the national diversity of grantee auspices and sizes (Figure 1).

The results of this survey provide insight into both the successes and challenges that Head Start programs and families currently experience accessing health services in their communities. In this report, NHSA presents the results, revealing the current state of health services, identifying existing needs, and proposing recommendations to improve access to and quality of these services.



Health Care Access

The first goal of the survey was to assess Head Start families' access to necessary health care providers. Survey participants were asked to describe their families' access to seven kinds of health care providers:

- Pediatricians or Primary Care Providers
- Dentists
- Mental Health Providers
- Nutritionists
- Occupational Therapists
- Speech/Language Therapists
- Physical Therapists

Survey respondents were asked to consider access to providers who accept Head Start families' insurance (primarily Medicaid) for preventative or follow-up care. As shown in Figure 2, programs report the highest level of access to pediatricians and primary care providers. Half of programs report that "Most or all families can access the services they need." Another quarter report that while most families have access, some communities they serve don't have enough providers. While this may suggest that the majority of families have adequate access to pediatricians and primary care doctors, 12.3% of respondents still report that there are a limited number of providers in their community and that families experience long waits for appointments. Given the importance of comprehensive care for young children, it is significant when any families experience difficulty accessing a provider who accepts their insurance.

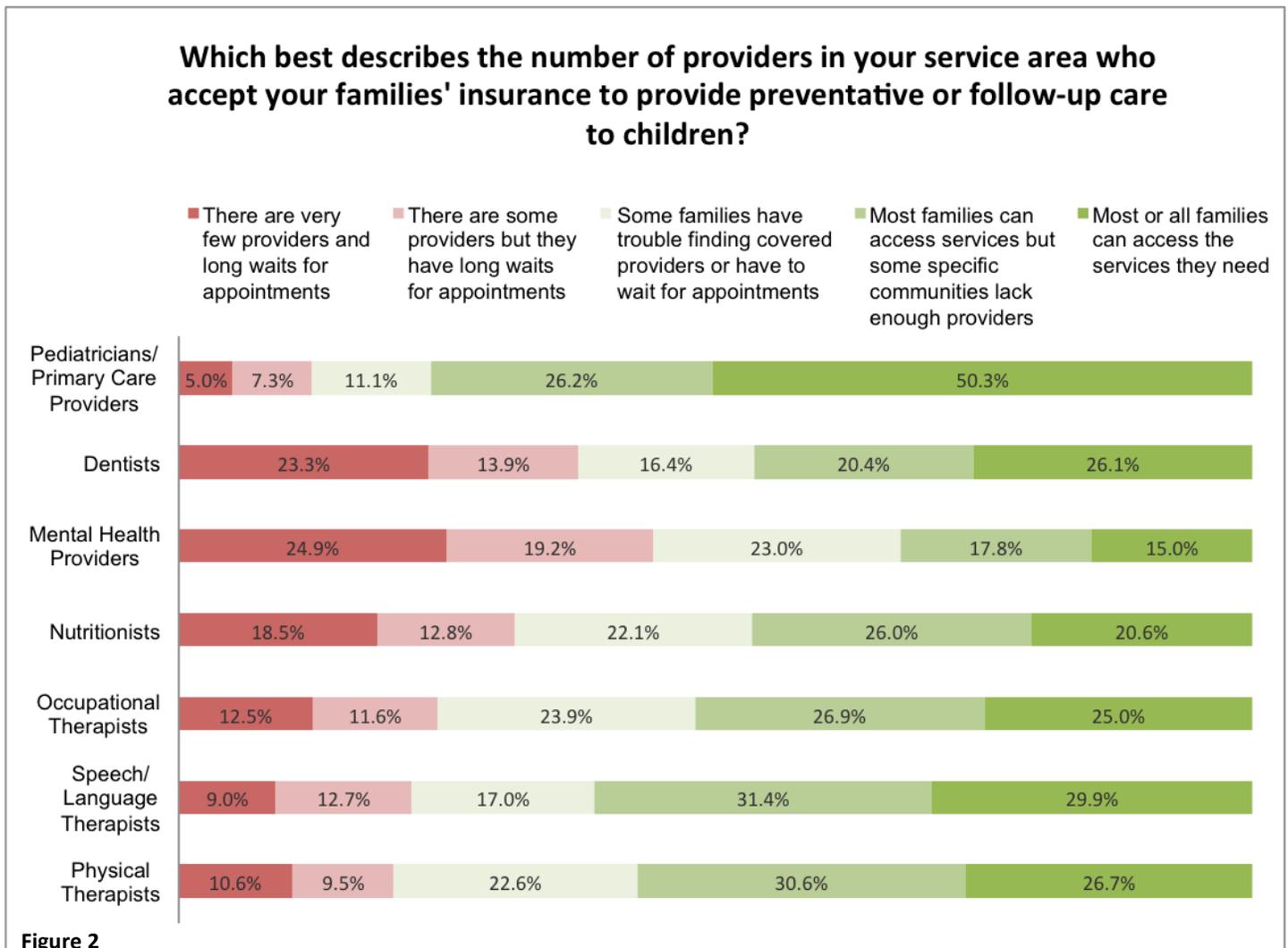
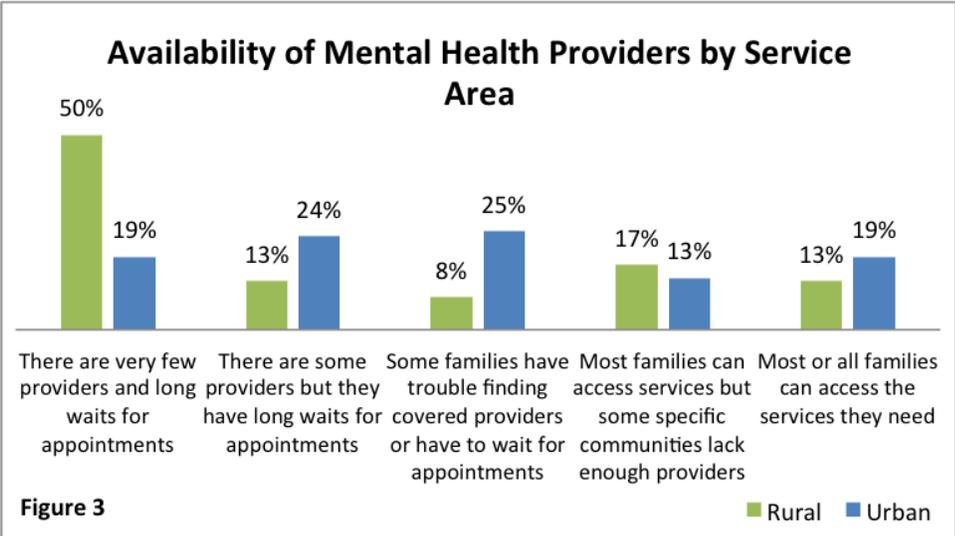


Figure 2

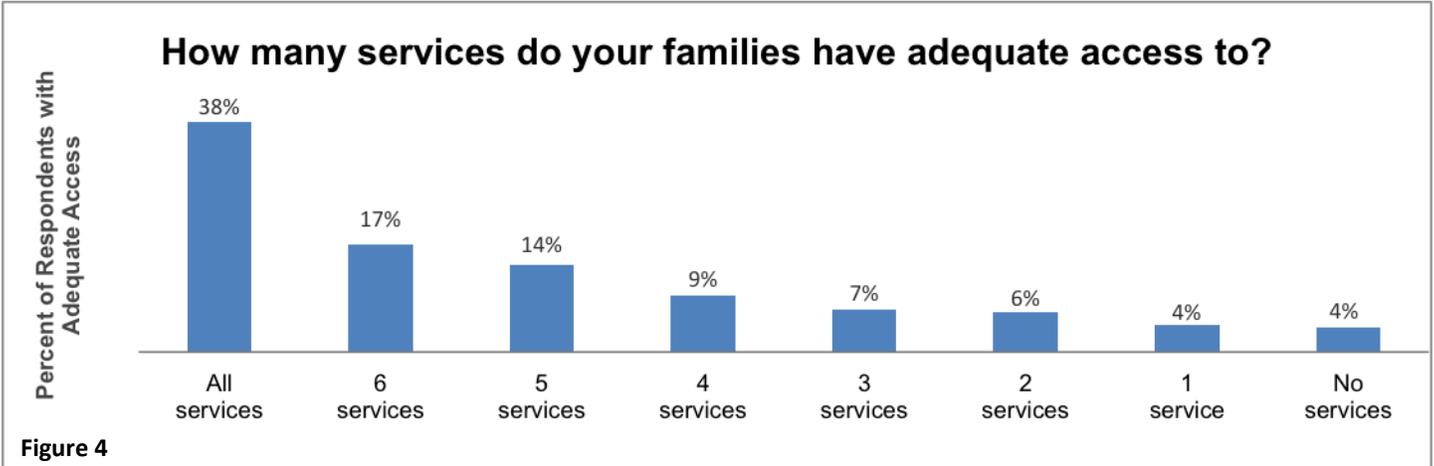
Aside from primary care doctors, all other types of services providers are significantly less accessible to families according to the survey results. In particular, medical specialists such as mental health providers or speech and language therapists are not accessible to Head Start families for preventative or follow-up care. Less than half of programs report most families having enough accessible dentists. When asked whether families have enough mental health providers, this number plummets even further. Less than one-third of programs report that most families can access the mental health services they need, while nearly half reported limited providers and long waits for appointments. Specialists, such as speech and language or physical therapists, are critical to identifying and treating disabilities and developmental delays, but the data clearly indicate that many children have restricted access to these services.

“We lack a good, solid partnership with our Mental Health partner as we only have 1 choice in our rural community and the services meet minimum requirements but nothing more.”

For families living in rural areas, programs report even more limited access to every type of provider. The percentage of programs reporting that most or all families have access to pediatricians or primary care providers drops to 62% while the percentage of programs reporting limited access grows to 30%. Access to specialists, such as mental health providers, is additionally disparate between families in rural and urban areas. More than 60% of programs serving only rural communities report limited access to mental health providers (Figure 3). While many urban communities also struggle with inadequate access to providers, and while they represent a larger number of families, rural communities consistently report more limited access across the board.



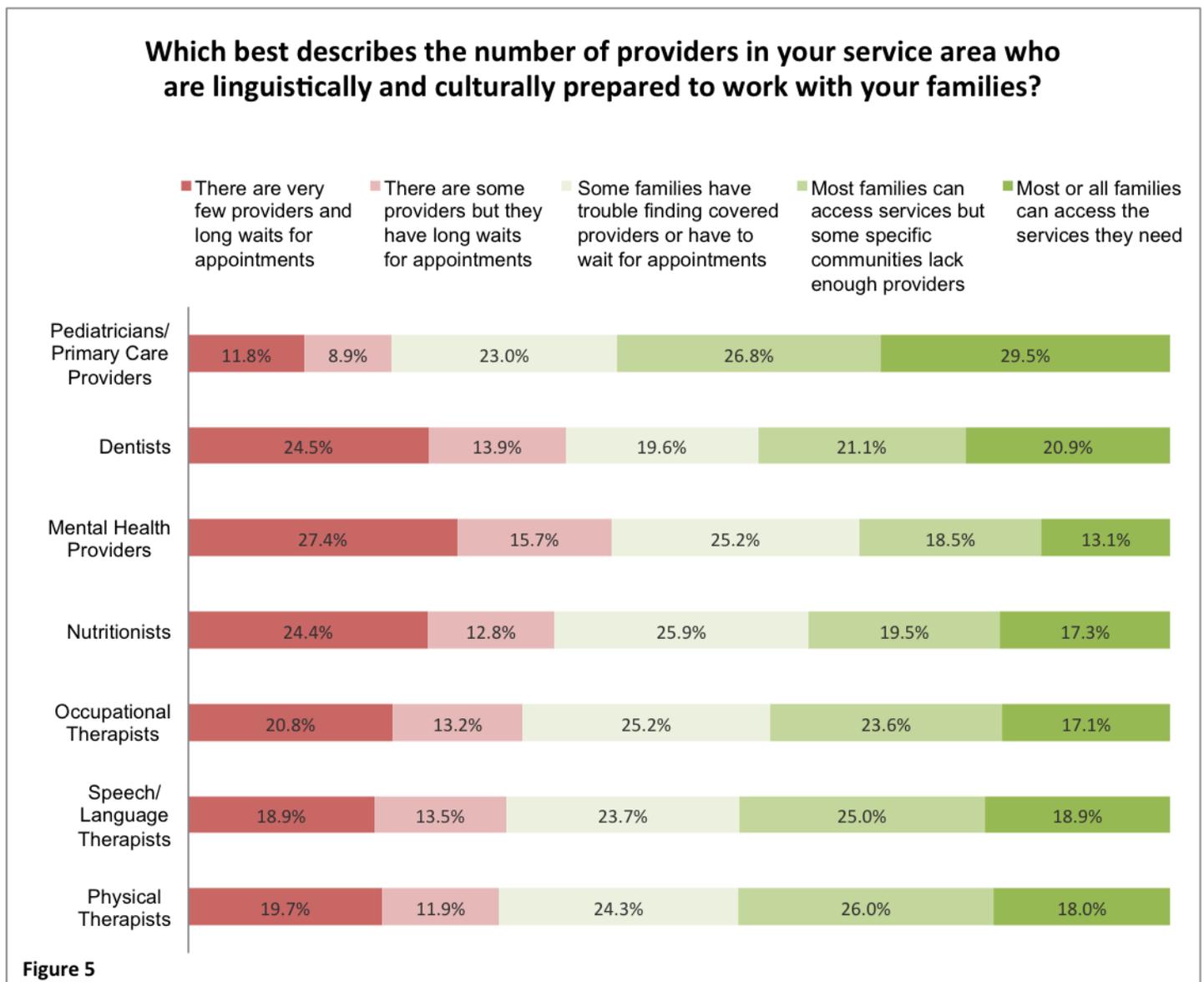
A deeper look at the survey responses examines whether certain families have limited access to multiple providers at once or if the lack of access was spread evenly, with most programs reporting adequate access to most programs and only limited access to one or two. As figure 4 shows, 38% of respondents report that families have sufficient access to all seven services. Another 31% report that families have access to most (five or six) of the seven services. However, the remaining 21% of respondents report that families lack adequate access to many or all services. (Here, inadequate access is defined as reporting “some” or “very few” providers and long waits for appointments.)



After asking about families' access to providers who accept their insurance, the survey asked respondents whether those providers were linguistically and culturally prepared to work with Head Start families. Head Start families come from a variety of countries and cultures and, according to the 2014-2015 Program Information Report, 29% of Head Start families speak a primary language other than English at home.

In considering the linguistic and cultural preparedness of providers, programs report significantly reduced access. When specifically asked whether families had access to *linguistically and culturally-prepared* providers, the respondents report half as much access to pediatricians or primary care providers (Figure 5). A similar trend appears in regard to specialists: nutritionists, occupational therapists, speech and language therapists, and physical therapists. The need for more bilingual speech and language pathologists was also reflected in open-form comments from survey respondents. While access to dentists and mental health providers is low overall, programs do not report that linguistic or cultural preparedness limited access any further.

We are trying to carve out small informal opportunities as well as formal large ones so we can empower families to advocate for themselves...Our program has hired an interpreter to assist the staff in communicating with Hispanic families in our program."

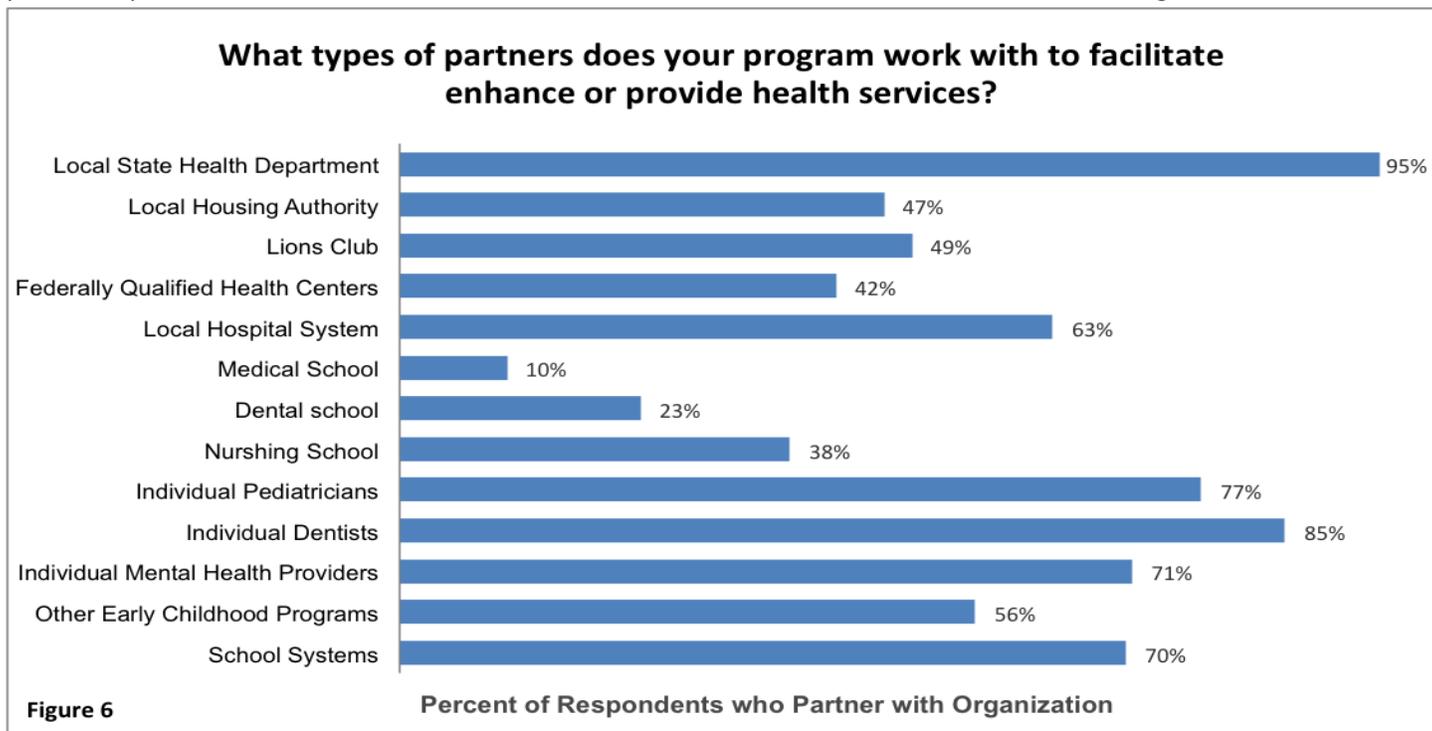


Partnerships for Health

Many programs build community partnerships to enhance their ability to offer comprehensive services. For Head Start programs, these partnerships play a powerful role in increasing access, and the Head Start model encourages these partnerships within the community. As such, the survey asked about which community partnerships programs established in order to better meet their families' health needs.

Respondents report a wide variety of organizations and agencies that they partner with, from state organizations to doctor's offices to local medical schools (Figure 6). Almost all programs report partnering with their state health department (95%). Other common partners include individual dentists (85%), pediatricians (77%), and mental health providers (71%). The survey results reveal that significantly fewer programs have created partnerships with their local universities, whether it be medical schools, dental schools, or nursing schools.

"We conduct a health fair in September of each year. Local dental hygienists provide fluoride applications. Nursing students from the local university help with heights, weights, vision, and blood pressure screens. The local audiology program completes the hearing screens. All time is provided in the form of in-kind and the church across the street from our school allows us to use their space."



Despite low partnership with certain types of organizations, most respondents report partnering with multiple organizations. On average, programs report partnering with at least seven different organizations to facilitate, enhance, or provide the required health services. The makeup of these partnerships predictably varies depending on the location of programs. For example, respondents serving purely urban communities are much more likely to partner with a local nursing school (41%) than respondents serving purely rural communities (8%). With medical institutions frequently based out of metropolitan centers, this is expected. By contrast, programs serving rural communities are 17 percentage points more likely to partner with Lions Clubs or similar local organizations.

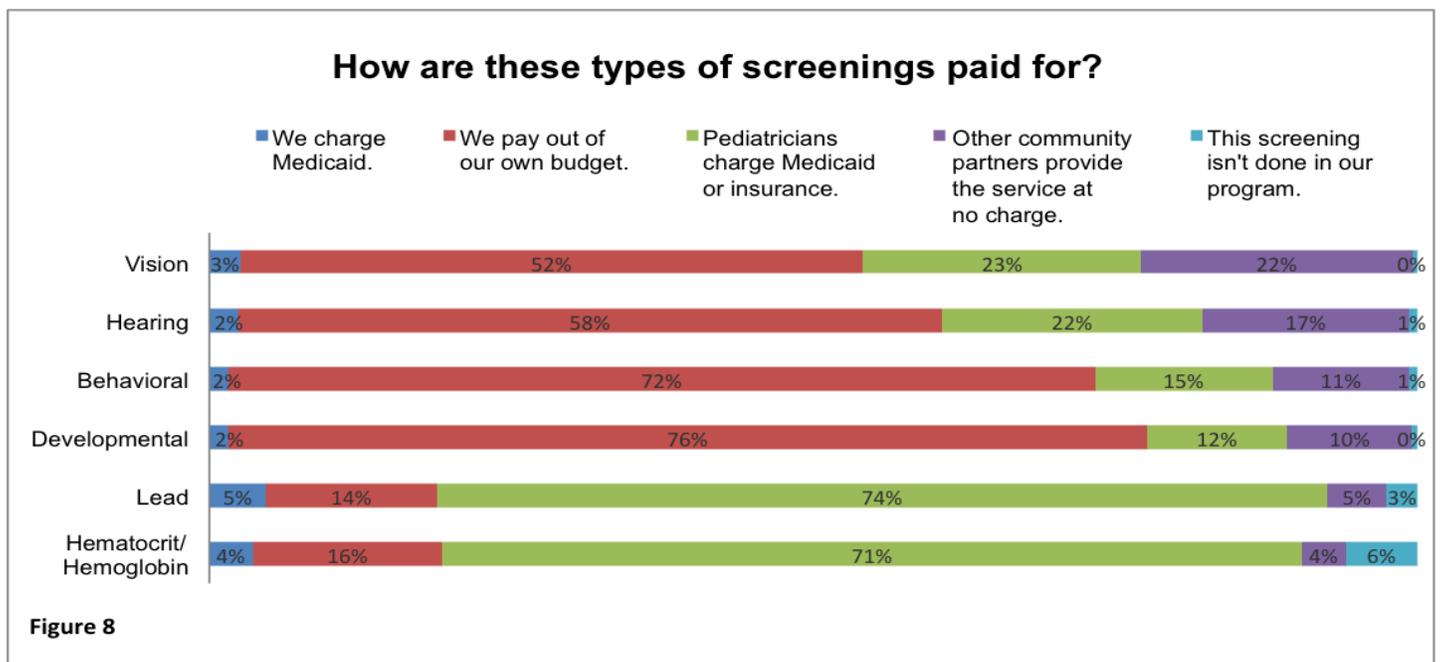
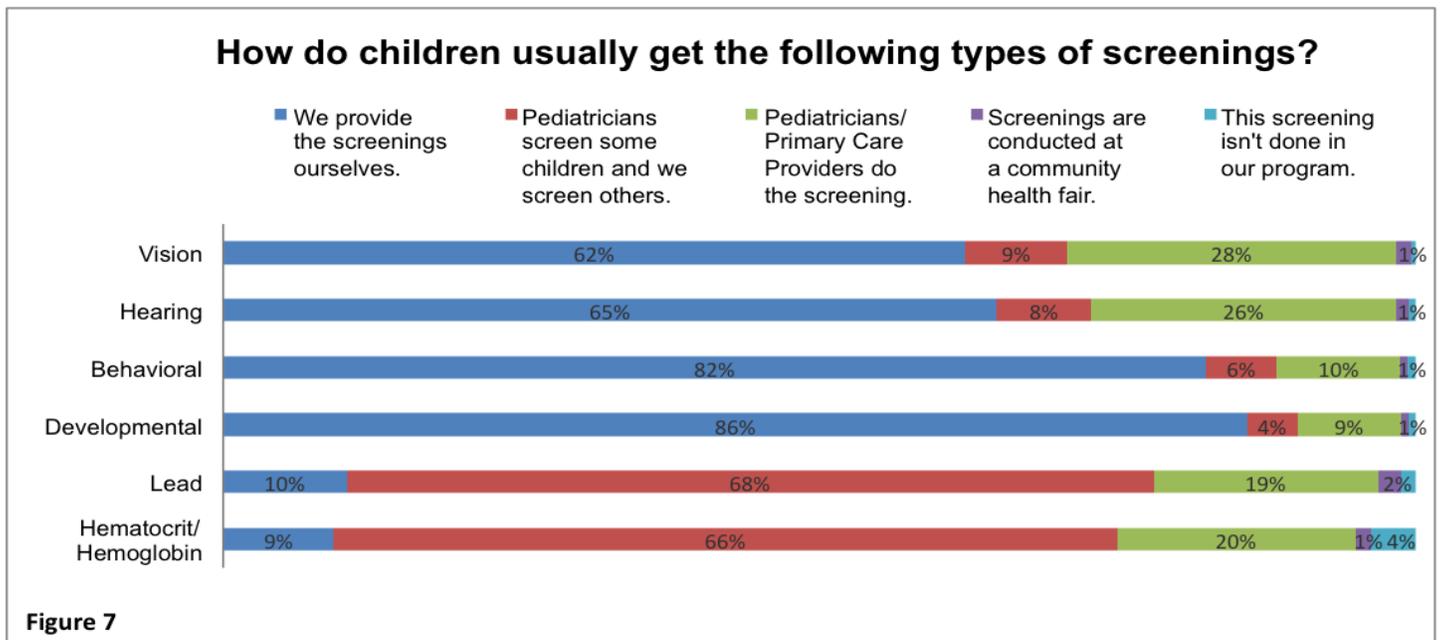
Many programs also shared in the comments that they work with organizations not on the list supplied, including but not limited to: WIC (Women, Infants and Children), additional specialists not listed, local clinics, United Way, private insurance providers, hospitals and Urgent Care locations, the YMCA, special needs providers, early intervention, military providers, and tribal health services. The sheer breadth of providers and the number of partnerships suggests an overarching need for collaboration around providing families with as much support and access to health services as possible.

Screening Practices and Payment

The Head Start Program Performance Standards require that Head Start grantees and delegates perform or obtain screening procedures to "identify concerns regarding a child's developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual, and emotional skills" within 45 days of a child entering their program (1304.20(b)). These screenings are allowable expenses from Head Start budgets but are also covered by Medicaid and the Children's Health Insurance Program.

"We do struggle with primary care physicians who do not follow required screening schedules according to EPSDT guidelines... Through our diligence children who may otherwise have gone undiagnosed have received glasses, PE tubes, and even bilateral hearing aids."

Survey responses suggest three separate patterns for how screenings are conducted and paid for (Figures 7 and 8). Vision and hearing screenings are handled and paid for similarly by programs, behavioral and developmental screenings show a similar pattern, and blood-related screenings (lead and hemacrit/hemoglobin) are handled a third way.



Nearly two-thirds of programs report providing vision and hearing screenings themselves, and more than half report paying for these screenings from their own budget. About a quarter report vision and hearing screenings are conducted by pediatricians or primary care doctors and are then billed to Medicaid. Another 17-25% of screenings are paid for by community partners. Only 2-3% of programs reported billing Medicaid for the cost of vision and hearing screenings.

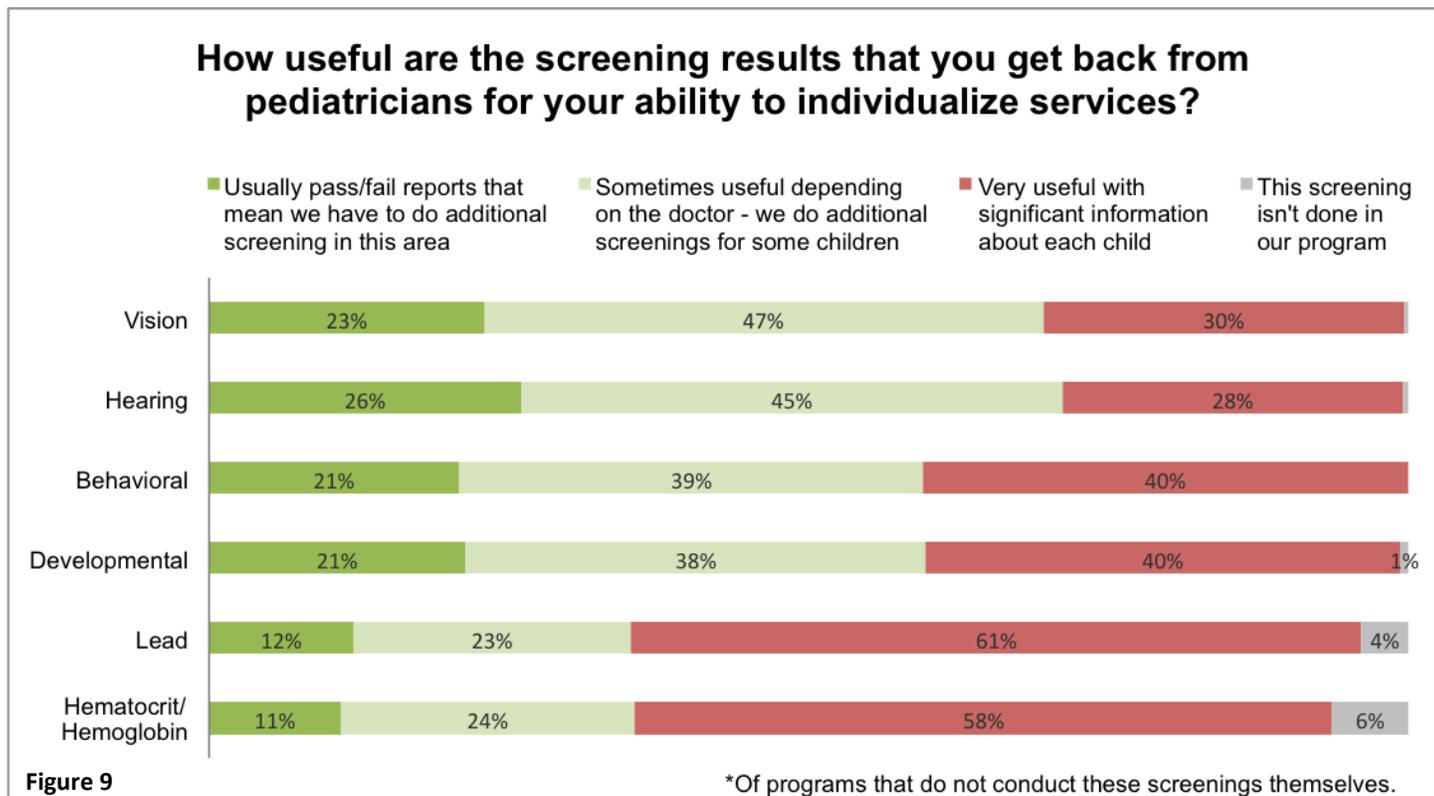
For behavioral and developmental screenings, more than 80% of programs conduct the screenings themselves. More than 70% of programs also report paying for these screenings out of their program budget. Only 10% of these screenings are covered by community partners and another 10-15% conducted by pediatricians or primary care providers who then bill the cost to Medicaid.

Blood-related screenings, those for lead exposure and anemia, are the most likely to be conducted by doctors and billed to Medicaid. Even still, two-thirds of programs report that “pediatricians screen some children and we screen others.” However, while programs do conduct a substantial number of blood-related screenings, only 15% report paying for these screenings with program funds. Five percent report billing Medicaid themselves, and the vast majority, more than 70%, report that the pediatricians bill Medicaid or private insurance.

“Along with the medical providers, we also provide hearing, vision, developmental, and behavioral screenings ourselves. The local health department also helps us out with lead and hemoglobin screenings if the screenings were not conducted by the medical provider. If the local health department provides the screening, we pay out of our budget for the screenings.”

When screenings are conducted by pediatricians or primary care physicians, it is still critical that the results be communicated properly to parents and programs. However, the survey responses reveal that if screenings are conducted by someone other than the programs themselves, programs frequently have to repeat these screenings anyway to get all of the information they need. This is because information about the screening results is not complete or is not shared with families and programs.

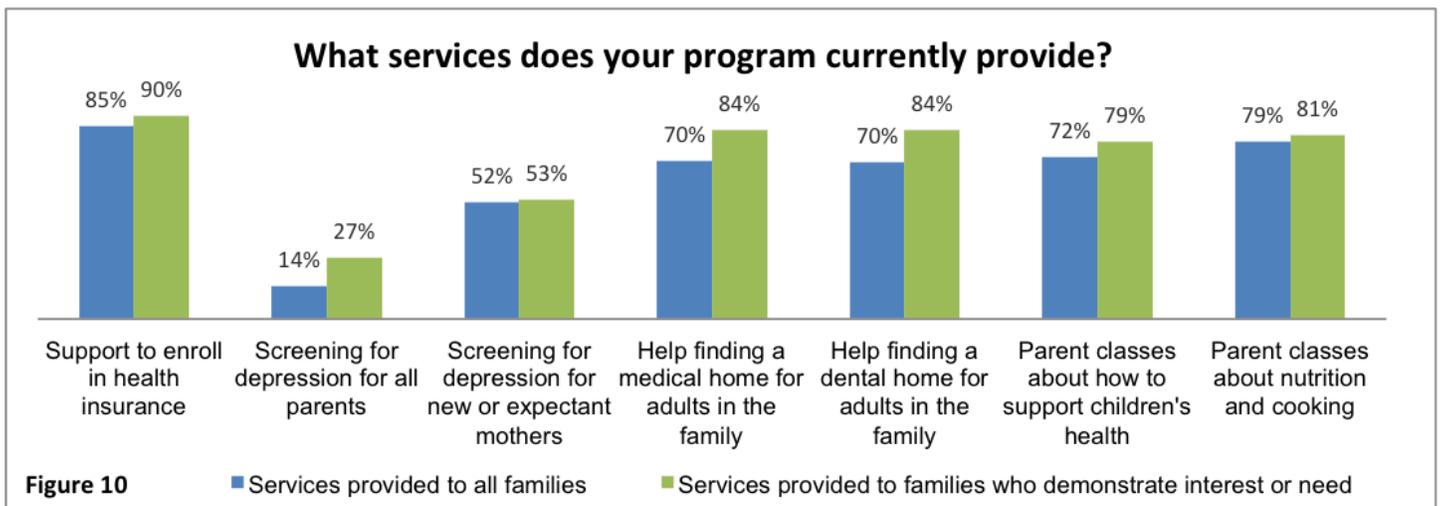
While approximately 60% of programs report receiving useful screening results for lead and anemia screenings conducted by doctors, rates are far lower for all other types of screenings (Figure 9). Only 30-40% of programs report receiving useful reports from doctors for vision, hearing, behavioral, and developmental screenings. Others have mixed results depending on the doctor, or they get pass/fail results that mean follow-up screenings are needed to gather enough information to appropriately individualize services and meet program requirements.



To confirm effectiveness of the screenings conducted, a parallel question asked programs whether needs identified by screenings are usually acted upon appropriately in the referral process. The survey asked participants, “If you refer a family to their pediatrician because of a need identified by screenings done by your program, does intervention or treatment happen appropriately?” While 58% of respondents report that referrals do result in intervention or treatment, 42% report that treatment and intervention “occasionally” or “almost never” happen or that, when intervention does happen, programs only sometimes get adequate information back from doctors about it. These results show that there is a large communication gap between programs and health care providers, resulting in an inefficient use of time and resources, not to mention inadequate treatment of identified medical needs of vulnerable children.

Two-Generation Support Services

Head Start programs provide a wide range of health education and support services to parents and families, too. In some cases, services may be targeted at families who set personal goals around a health need; in others, supports are generally offered to all enrolled families. For most services the survey asked about, at least 70% of programs report offering support to all families. When families express an interest in a particular service, upwards of 80-90% of programs report being able to support them (Figure 10).



Despite most programs being able to successfully offer necessary services to families in need, mental health services remain the category that lags behind. Only half of programs report providing screenings for depression new or expectant mothers, and very few are able to provide this screening for all parents. At the same time, screenings for depression for all parents was the most common answer for what service programs would offer if they had additional resources, with more than 57% of respondents wanting to offer this service. Given previous results showing the limited availability of mental health providers, particularly in rural areas where half of respondents report few providers and long waits, these results are not surprising, but are cause for significant concern as they paint a stark picture of the challenges facing many programs.

Health in the New Head Start Program Performance Standards

In November 2016, new Head Start Program Performance Standards (HSPPS) went into effect, updating for the first time in decades the requirements and procedures that all Head Start programs must follow. The new Standards maintain health as a critical component of the Head Start model, retaining previous requirements about screening and ongoing care, but also strengthening and expanding the role that programs play in ensuring health services for their children and families.

The HSPPS include specific timelines that programs must meet specific milestones. Within 30 days, programs conduct a home visit and determine if each child has continuous access to health care. Then, within 45 days, vision and hearing screenings are completed. Within 90 days, programs must assess whether each child is up-to-date on Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) well child and dental periodicity schedule, immunization recommendations from the Centers for Disease Control and Prevention (CDC), and nutrition needs. The findings of these assessments inform ongoing care in which programs use observations to identify and track individual health concerns, including referrals and services. For children who require extended follow-up care, programs facilitate diagnostic testing and treatment. Within the first 90 days at a Head Start program, children receive a comprehensive assessment while parents receive support around how to follow recommended schedules.

In the new Standards, there is also an increased focus on mental health, oral health, and parent education in health issues. Specifically, in the area of mental health, there are explicit requirements around how programs can integrate mental health into practices to improve classroom management and support staff who address challenging behaviors. The new Standards focus creating a positive culture around mental health and social emotional well-being by ensuring that mental health consultants are integrated into program practice from the very beginning and requiring programs to obtain parental consent for children's mental health services at the time of enrollment for every child. With regards to oral health, the new Standards require that programs "facilitate and monitor necessary preventative care, treatment and follow-up, including topical fluoride treatments," building on a requirement maintained from the previous standards that programs help children brush their teeth once daily.

The new Standards recognize the powerful role of both mothers and fathers in their children's health. Thus, programs collaborate with parents around meeting children's health needs, with a focus on parents with low health literacy. Programs are required to help parents to ensure that children are up-to-date with preventative and primary care and even assist in obtaining medication when necessary. There are a number of other health education opportunities that programs are required to provide to their parents. For example, programs are required to provide opportunities to learn about preventative care, emergency first aid, environmental hazards, tobacco use, lead and safe sleep, among many others.

Every aspect of health in the new Standards incorporates flexibility for programs to adapt to meet specific local and family needs. At a family level, programs are required to both collaborate and communicate with parents about children's health in a linguistically and culturally appropriate manner. All services are individualized based on need. For example, with regards to the use of mental health consultation, the Standards require that programs address these needs through strategies for support in classrooms and on "a sufficient and consistent schedule" for staff and families. At a program level, programs must consider recommendations from local Health Services Advisory Committees and evaluate other deficits and strengths, such as fluoride levels in local water supplies.

The Office of Planning, Research, and Evaluation: Head Start Health Matters Findings

The Office of Planning, Research, and Evaluation under the Administration for Children and Families recently published a report, "Head Start Health Matters: Findings from the 2012-2013 Head Start Health Manager Descriptive Study for Regions 1-XII," which examines the state of health services in Head Start. RAND Corporation conducted the study to uncover in-depth information about the challenges of providing health services, the needs of health managers, and the context in which these services are provided. The final report covers a wide array of topics, from who makes up the health workforce in Head Start to what types of community partnerships programs have created.

The report's findings align with the information collected through NHTSA's survey and approach the topic with specific regard to workforce. With the findings of the current survey confirmed by the OPRE report, NHTSA recommendations for addressing the current challenges, expanding access, and improving the quality of health services in Head Start complement the suggestions of the OPRE report.

Barriers to Quality Care

In addition to the limited number of providers and difficulty communicating between parents, providers, and programs, transportation and translation services are cited as barrier to quality health care. Programs frequently report that families may have trouble finding consistent and reliable transportation to get to their medical appointments, and some families face a language barrier with their local providers. In the case of children and families who do not have transportation or do not speak English, programs often use their own resources—both staff and funding—to meet these needs.

"Public transportation is available, but doesn't go everywhere a family may need. [In our] very rural area, most specialists are 50-75 miles away in the city. Mental health services for children under 5 are non-existent in our community, and the only place for children 5 or under is a facility one hour away."

About half of programs report providing transportation and interpretation services for families and paying for these services with Head Start program funds, even though Medicaid offers these services. Even for programs and families who know that Medicaid can fund transportation or translators, respondents note that there can often be long waits to access these services through the Medicaid system and that many of the state Medicaid systems are difficult to navigate. As a result, many programs opt to provide the services themselves using existing staff and/or program funds to meet families' needs quickly. When asked what additional resources they needed, 65% of survey respondents requested information and support to help families access Medicaid coverage for these services.

Innovating for Success

Across the country, Head Start programs find innovative ways to overcome the challenges they confront as they provide access to high-quality medical services. The survey results reveal several creative methods programs use to improve the quality and the efficiency of the health services they provide.

For example, in order to minimize transportation barriers and expedite the numerous screenings that must be completed early in the program year, multiple survey respondents report hosting health fairs at their centers, bringing children, families, and health providers together in one central location at one time. One program reports holding their health fair before the school year begins so there are fewer screenings to conduct in the first few days and families can avoid visiting providers' offices at a typically busy and understaffed time of year. Otherd collaborate with their local providers to streamline access for families and make the providers aware of Head Start's requirements so that screenings are conducted properly and the results are more successfully communicated to families and programs.

"Pediatricians are provided with highlighted forms that show the screenings they should be providing during checkup. However, many children return with these forms incomplete. Vision and hearing sections are often marked 'too young to test.'"

Even still, programs across the country continue to face challenges as they work tirelessly to provide quality health services. When local services are inadequate, Head Start programs compensate with their own resources to meet the needs of their children and families. Both the quantitative and the qualitative data make it clear that Head Start programs confront a variety of challenges to providing health services to their children and families. In response, many programs have made innovative and adaptive changes to better meet their unique needs and, while Head Start continues to have a positive impact on the health of the children and families in the program, specific steps at the federal, state, and local level can be taken to expand access and increase quality of health services across all Head Start programs.

Recommendations

Based on the results of the survey, NHTSA has developed several recommendations to support and improve the work done by Head Start programs around health services. The recommendations, outlined below, are organized according to the entities best suited to make change. Opportunities for improvement and support are available from the federal systems level all the way down to the individual Head Start practitioner level.

At the Federal Level

- **The Administration for Children and Families should collaborate with the Centers for Medicaid and Medicare Services to streamline collaboration between Head Start programs and Medicaid at the state and local level.** The agencies should issue guidance to states to establish procedures for Head Start programs to register as Medicaid providers or contract with existing Medicaid providers in their communities. This collaboration would expand access to and increase awareness of programs looking to get reimbursed for the services and screenings that are currently being provided at the cost of the program.
- **The National Center on Early Childhood Health and Wellness should include training and technical assistance on how to access Medicaid services.** These resources should include information on how to bill Medicaid, enroll families in health insurance, empower families as advocates for their own health, cultivate health partnerships around health, and educate local health providers on EPSDT standards.
- **Congress and the Administration should continue to expand investments in health infrastructure.** Existing federal investments, including opportunities such as the Health Professions Opportunity grants and Federally Qualified Health Centers (FQHC), increase access to health providers in regions and neighborhoods with limited access. Additional investments continue to build on these targeted efforts, such as the Centers for Medicare and Medicaid Services' [Frontier Community Health Integration Project](#) and American Academy of Pediatrics' [Healthy Tomorrows Partnership for Children Program](#).

At the State Level

- **States should take action to include maternal depression screening as part of the EPSDT well child visits covered by Medicaid.** Maternal depression is a serious condition that affects the wellbeing and quality of life of both mother and child. AAP estimates that, among families living below the federal poverty line, more than half (55%) of infants live with a mother suffering from depression. States should look to Colorado, Illinois, North Dakota, and Virginia, the states leading the way in increasing access to screening for maternal depression through these means. ([CMCS Informational Bulletin 5/11/16](#)). Local chapters of American Academy of Pediatrics can assist in moving this action forward ([Maternal Depression Screening: Medicaid and EPSDT Coverage](#)). In states that successfully implement this change, advocates can look to New York as an exemplar state that has gotten maternal depression treatment coverage through the same means.
- **States should support, formalize, and expand the roles of Community Health Workers (CHWs).** CHWs, also sometimes referred to as Promotores de Salud, Community Health Advisors, or other titles, have the potential to improve health care delivery, increase access to health services, and ensure culturally and linguistically appropriate care in the neighborhoods they serve. The vast majority of states have not taken or introduced legislative or regulatory action regarding CHWs' education, certification requirements, or payment through Medicaid, despite benefits such as an increased capacity to provide preventative care to underserved populations. States have multiple options for creating pathways for Medicaid reimbursement for CHW services. States should create mechanisms for CHWs to be reimbursed by Medicaid for services that are recommended by physicians (CMS-2334-F). Alternatively, state Medicaid programs could pilot innovative approaches to services, including utilization of CHWs (Section 1115 of the Social Security Act). ([DHHS ASPE Issue Brief](#))

- **Medicaid agencies should collaborate with Head Start State Associations and local programs to create streamlined access to the Medicaid system.** Through this collaboration, Head Start children and families could more easily and efficiently access care, and programs could more effectively provide services and bill Medicaid.
- **States should create systems of enforcement and accountability to ensure that the services covered by Early Periodic Screening Development and Treatment (EPSDT) are delivered reliably to all Medicaid recipients.** Many programs report that health providers in their communities do not adhere to EPSDT guidelines. The Medicaid system should hold providers accountable for completing required screenings and communicating this information effectively to parents. New, more accessible systems for patients and programs to report issues should also be established.

At the Practitioner Level

- **Head Start programs should convene health committees in their community to bring together all local entities serving the same population.** Because of Head Start’s powerful role as a convener within communities, Head Start programs should formalize opportunities to discuss collaboration about health services, share data to increase effectiveness, and ensure cultural and linguistic needs are met across the entire range of services.
- **Head Start programs should create open lines of communication between programs and local medical practices to ensure an understanding of Head Start needs and requirements and spark discussion around possibilities for collaboration.** Practitioners should look to exemplar program practices and processes and the training and technical assistance provided by the National Center on Early Childhood Health and Wellness.
- **Head Start programs should establish procedures for getting reimbursed for the required services and screenings that are completed in programs.** Survey findings show that programs frequently use program funding to pay for medical screenings. While this is an allowable expense, screenings are also qualified Medicaid expenses. With programs paying for the screenings themselves, there is less funding for educational services, such teacher salaries, classroom supplies, or facilities updates. Whether through familiarizing themselves with state requirements or by contracting with existing Medicaid providers, Head Start programs that are reimbursed for the screenings and services they provide will be able to reallocate these funds for other purposes.
- **Head Start programs should empower their families to be advocates for their children’s health.** Programs should arm families with information about Medicaid entitlements covered by the EPSDT benefits, as well as information about exemption from out-of-pocket charges. Medicaid enrollees are entitled to any service or treatment necessary to “correct or ameliorate” physical and mental illnesses or conditions. (CMS rules and regulations) These include, but are not limited to:
 - Services provided by physicians, nurse practitioners, and hospitals;
 - Physical, speech and language, and occupational therapy;
 - Home health services, including medical equipment and supplies;
 - Treatment for mental health and substance use disorders; and
 - Treatment for vision, hearing, and dental diseases and disorders, including eyeglasses, hearing aids, and preventative dental treatment.

Individuals enrolled in Medicaid are *entitled* to these services and services for children are exempt from out-of-pocket expenses. Families must have this knowledge, and programs should empower them to take action to ensure they receive the appropriate services.

- **Head Start programs should hold summer health fairs and encourage families to complete necessary medical check-ups during recruitment and enrollment periods.** Summer health fairs can complete a significant portion of a program’s screenings before the school year begins. Programs have a heavy workload in the first 90 days of a new program year, and getting these services started as early as possible can alleviate some of this workload.

As a National Membership Organization

- **The National Head Start Association will research and disseminate information on exemplar program practices to the field.** NHSA will continue to monitor and assess health care access and services in the field and will share lessons learned through case studies, webinars, and other similar means.
- **NHSA will facilitate connections with foundations and advocacy organizations to support the recommendations detailed above.** NHSA will reach out to foundations committed to the health and well-being of children and families to encourage additional investments in infrastructure, policies, and practices that support health as a base for school readiness. Similarly, NHSA will work with other advocacy organizations representing the early childhood community at large and low-income families in general to pursue federal and state policy reforms that support the health of vulnerable children and their families.
- **NHSA will coordinate with the National Association of Community Health Centers to improve partnerships between local centers and Head Start programs.** Federally-funded Community Health Centers are critical to providing affordable primary care services to Americans nationwide. NHSA will work with NACHC to identify ways to encourage partnerships at the local level and to educate the health center workforce on Head Start screening requirements.