WORKING PAPER

Strategies for Promoting Health and Assuring Access to Health Care in Child Care Settings

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COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH

The **National Center for Children in Poverty** (NCCP) was established in 1989 at the School of Public Health, Columbia University. Its mission is to reduce dramatically the number of young children living in poverty in the United States, and to improve the life chances of the millions of children under six living in or near poverty.

The Center:

- Alerts the public to the serious impacts of poverty on young children, their families, and their communities.
- Conducts pragmatic, demographic, and field-based research to clarify which programs and policies work best for young children in poverty.
- Synthesizes knowledge in the areas of health, early childhood care and education, and family and community support, which can guide the actions of elected officials, government representatives, and nongovernmental organizations.
- Convenes workshops and seminars to bring public and private groups together to assess progress in reducing young child poverty rates.
- Challenges policymakers and opinion leaders to apply proven techniques to reverse the adverse consequences of poverty on young children.

The Center's publications program is funded largely through core grants from the Ford Foundation and the Carnegie Corporation of New York.

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ISBN 0-926582-14-3

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Promoting Child Care/Child Health Linkages

Preschool children increasingly receive care away from their homes. This results from more parents working or seeking work, or because families value the out-of-home child care experience, or both. Currently, almost half of all three- and four-year-olds from low-income families participate in center-based care, while others are cared for in family day care homes.[1] In many communities, budget state and local health care and welfare reforms are changing the ways in which young children gain access to health care, including preventive and acute care services. As a result, many preschoolers enrolled in child care have health needs that are not being met.

The purpose of this working paper is to explore ways in which the child care community can work together with the health care community to promote child care/child health linkages, even in an uncertain political context marked by profound changes in health care delivery systems and shrinking resources for the early childhood community.

The challenge

Child care providers have a variety of connections with health care providers, but few collaborate with each other systematically. In almost every state, licensed child care centers require preschool children to be immunized as a condition of entry. Prekindergarten programs operating within school systems have similar requirements. Head Start, however, is the only major program that routinely requires preventive health and dental care and treatment for enrollees, and many local Head Start directors report difficulty obtaining health services from community providers for enrolled children.[2] Neighborhood family day care homes, which care for at least 30 percent of young children whose mothers are employed, remain even more isolated (than centers) from routine health screening systems.[3]

Children from low-income families have higher rates of illness and injuries when compared with other income groups.[4] Yet barriers to health care exist, as the following examples illustrate:[5]

- Counties with a predominantly low-income population have fewer than half the number of primary care physicians who treat children than higher-income counties have.
- Uninsured preschoolers make less than half the number of physician visits annually (2.8) than poor children receiving Medicaid (6.0) make, although the health needs of these two groups are comparable.
- Preschoolers living in low-income zip codes are more than four times as likely to be hospitalized for asthma as those living in high-income zip codes.

The consequences of unmet health care needs for preschoolers from low-income families are expensive for both the communities and the states in which they live in. For example, hospital emergency care teams end up treating children for problems that could easily be treated or prevented in a less costly health clinic or doctor's office. Elementary school districts administer special education for children whose problems could be identified and treated earlier in an early childhood program.

Local child care providers are aware that many of the children in their care do not receive the diagnoses and treatment they need to prepare them for entering school. They frequently have difficulty dealing with acute and chronic health problems experienced by children in the classroom. Many of these children are not enrolled in an ongoing source of quality, comprehensive health care. Further, without the resources to hire and train health and family services workers, child care administrators cannot educate parents about the importance of preventive health care and assist them in obtaining health care services in the community. These are the parents who are also at risk for having younger infants and toddlers with illnesses and chronic health or behavioral problems.

As more young low-income children spend longer hours each day in child care centers and family day care homes, state policymakers and community leaders have recognized that the child care setting has a role in addressing health needs of these very young children. Many state leaders also acknowledge that child care workers need better training to identify the signs of illness or emotional distress in children. Some have seeded initiatives to promote children's access to medical diagnoses and treatment, whether they have health insurance or not. This working paper explores strategies that states and communities can use to promote new or expanded child care/health care linkages and illustrates them by describing community-based initiatives.

The larger context: Opportunities and uncertainties

The 1990s federal child care funding programs have helped states strengthen some of the systems that protect the health and safety of children enrolled in child care centers and family day care homes. The 1990 Child Care and Development Block Grant Act (CCDBG) specifically asks states to review and report on the health and safety requirements of child care licensing agencies.[6] In addition, the Act requires states to assure that licensing, regulation, and training to protect the health and safety of children is in effect for all providers supported by the new funding. The oversight agency, the Administration on Children, Youth, and Families, launched a new initiative in 1994 to focus on health concerns in child care and encourage new partnerships to promote child health. This Healthy Child Care America Campaign is co-sponsored by the Department of Health and Human Services Maternal and Child Health Bureau, which administers the Title V Maternal and Child Health Block Grant.

Regardless of funding sources, child care administrators and health agencies can take many steps to meet child health needs in the context of child care. Three approaches are most promising in linking children enrolled in child care to health care and in promoting comprehensive service systems:*

- **Develop new statewide and communitywide initiatives to promote child care/ health care linkages to support targeted local programs.**
- **Heighten the awareness of health and child care administrators about health needs and opportunities—by informing them about Medicaid expansions, state plans for managed care, and state health insurance plans for the working poor.**
- **Encourage local comprehensive services initiatives for preschoolers that include health components, through interagency agreements and collaboration.**

The following sections of this paper describe more fully each of these strategies.

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* Our findings rely on a preliminary search of written materials about state and local early childhood programs that have specifically developed collaborations with health agencies to address the health care needs of enrolled children. These state and local examples have emerged out of larger comprehensive service initiatives, in connection with Head Start expansions, in response to new block grant funding, or as state prekindergarten initiatives. They may not represent the best of current efforts, nor are they exhaustive. They have, on the other hand, received attention in recent newsletters and papers prepared for child care, family support, and maternal and child health conferences.

STRATEGY I. Develop new statewide and communitywide initiatives to promote child care/health care linkages

To promote effective health care and child care collaborations, child care and health administrators may find a mix of strategies useful. Most of these strategies are best implemented on a communitywide basis and should include Head Start and relevant state prekindergarten programs if possible. Head Start and state prekindergarten grantees typically have health objectives embedded in their funding requirements, and local programs may find that collaboration is the only practical means to represent the health needs of large numbers of children before state and local health agencies.

Other potential collaborators might include the agencies and groups described below:

State Title V and Medicaid agencies. State maternal and child health agencies administer the Social Security Act's Maternal and Child Health Block Grant and are responsible for assuring access to health care for each state's most vulnerable groups of mothers, infants, and children. State Title V agencies, which work closely with their Medicaid counterparts, can be valuable partners in designing linkage programs. If there are state matching funds, the agencies can suggest ways to use Medicaid financing for reimbursing qualified providers for outreach, case management, preventive health screens, and treatment. In many states, the Title V agency and Medicaid are trying to increase the number of children receiving immunizations, and also to increase the number of Medicaid children receiving health screenings through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Some local health departments, many of which receive Title V funding, have ongoing cooperative agreements with Head Start, and several state Head Start collaboration projects have facilitated Medicaid enrollment for children in Head Start.

State health insurance plans for low-income families and children. Some states have passed legislation that authorizes general tax revenues or that designates special taxes for financing preventive and ambulatory care insurance for children not receiving welfare or Medicaid. For example, New York has implemented Child Health Plus, a statewide insurance plan, and in 1989 California expanded its Child Health and Disabilities Prevention (CHDP) program for low-income children to include diagnosis and treatment—using state funds from a cigarette tax. Child care administrators can work to develop agreements with the state agencies that administer such plans to assure enrollment for uninsured children who receive subsidized child care and their younger siblings.

Managed care organizations. About 42 states now enroll Medicaid beneficiaries in managed care programs, using federal waivers. This trend affects many young children from low-income

families.[7] Child care administrators can advocate for the children at the state level by working with the agencies that regulate managed care. They can also promote local collaborations between child care programs and managed care through child care resource and referral agencies or through local child care agencies. For example, in a community where most of the children in subsidized child care are Medicaid-eligible, child care providers and managed care plans can work together to inform families about the new service system, and can ensure that they receive services covered under EPSDT. However, managed care plans in most states are not required to track or report how many children enrolled in Medicaid have received immunizations, EPSDT screenings, or follow-up treatment.[8]

School-linked health clinics. The number of school-linked health clinics, although still very small, has increased dramatically in recent years with funding from foundations, state health departments, and other state revenues. Nationally, about 25 percent of these clinics are in elementary schools,[9] which also frequently house state prekindergarten and Head Start programs. A few Head Start centers, as in New York and New Jersey, have contacted community health centers to initiate clinic services at the centers for enrolled children and their siblings.[10] If quality set-aside provisions, now part of the CCDBG, continue in some form in either federal or state legislation, states could promote this type of collaboration, with health care services reimbursed through Medicaid or another state child health insurance initiative.

Head Start state collaboration projects. At least 30 states now have collaboration grants from the Head Start Bureau. While these projects mainly promote collaboration between Head Start and child care programs, several of them address health concerns. Achievements have included a Medicaid/Head Start funding agreement in Maine, a Medicaid outreach initiative in New Jersey, and a dental care survey in Maryland. These collaboration projects could do more if support were added from other state funds, including the CCDBG.

Child care and health agencies should consider especially the following health promotion components:

- Small grants can encourage child care providers to establish links with health care agencies**.** For example, the Maryland Department of Health and Mental Hygiene made a grant to the state child care agency to train child care providers about the importance of immunizations.[11]

- Establishing a state task force on child health or child care can move a child health promotion and assurance agenda forward**.** Washington State, for example, has an interagency child care coordinating committee that includes representatives from the health and education department(s) along with child care subsidy agencies. As members of this committee the state's maternal and child health agency director and the Seattle-King County Health Department

have facilitated planning for new initiatives between child care and health care groups.[12]

- Ad hoc working groups can be an effective way to create partnerships around specific concerns, such as dental care, mental health, or Medicaid enrollment. State and local working groups should include representatives from key organizations involved in child care and health care.

Strategy II. Heighten the awareness of health and child care administrators about health needs and opportunities related to child care

State child care and health administrators should monitor changes taking place in the health care system that may affect the ability of low-income families with young children to obtain health care. Even though national health care reforms have been delayed, many state health agencies are expanding financial access to health care for children beyond the 1989 federal mandates established for Medicaid and the reforms in the Medicaid EPSDT program. Some states are creating systems of managed care for all Medicaid recipients. Implementation of managed care at the local level has been uneven, however, and many parents as well as social service agencies are confused about eligibility requirements and how to find providers.

To learn more about state health care system changes and the specific barriers to health care faced by low-income families and children, state and local child care administrators should consult on a regular basis with their counterparts in the school, public health, social welfare, and mental health systems. In addition, they can frequently obtain useful information about emerging health concerns and access issues from child care health consultant or Head Start programs. Such consultations are especially important during a period of budget cuts and service reconfigurations in order to increase the likelihood that serious problems will be recognized by policymakers.

The following examples illustrate some strategies that have been used to raise awareness among health agency administrators and child care providers about health care concerns and issues on a communitywide or statewide basis:

- Child care health consultant programs, when organized centrally, can collect information systematically and respond more efficiently to the common health and safety needs of groups of child care centers. For example, the child care nurse consultants who work under contract with the Minneapolis Health Department, on a program described later in this paper, have begun to conduct simple surveys of health-related needs and practices in the child care centers they visit regularly. Such surveys augment regular reports and routine administrative records that document health related activities.
- Head Start programs can be another excellent source of information about child health needs and access issues. Programs may have developed ways to help families enroll their children in Medicaid or obtain other subsidized health

insurance. In addition, each program maintains a health record for each child, and the health coordinator in each center may be able to review them in order to estimate the numbers of children affected by specific conditions and to gauge unmet needs for diagnoses and treatment. Or, the program director and staff can collate existing reports to produce rough estimates.

For example, three concerned groups used these methods to document health concerns of Head Start and child care providers on a state and regional level. The Maine State Collaboration Project conducted a comprehensive study with all Head Start grantees, including a review of health records; the federal ACF office in Region II supported a health survey of Head Start programs in New York, New Jersey, and Puerto Rico; and the New York Council on Children and Families conducted a short comprehensive needs survey (which included health concerns) of local Head Start, early childhood, and child care providers.

STRATEGY III. Encourage local comprehensive services initiatives for preschoolers that include health components

The previous two strategies emphasized the roles of health and child care administrators as they work with counterparts in other state agencies serving poor families with young children—with the goal of promoting better linkages and adding health components to child care or family support programs. A third strategy is for states to give funding preference to health programs that develop local collaborations with health care providers. For example, administrators can increase children's access to health services by giving child care providers access to categorical funding traditionally associated with health, family support or education, or special funding that promotes community collaborations for children. These funds can become community catalysts for designing comprehensive service systems that enable children enrolled in child care to receive health care.

Examples of promising approaches that enhance health services appear below, demonstrating how state and community agencies can improve access to health care for the children and families served in early childhood programs. These examples are grouped under three health assurance goals for child care providers.

Goal A: To assure that poor children receive preventive health care services

Preventive health care for preschoolers has three important functions: immunizations to prevent serious communicable diseases such as measles and diphtheria; screening tests to detect problems; and anticipatory guidance and parental counseling to help parents manage treatment for chronic conditions. An ongoing source of health care reinforces all three functions.

The child care provider's role in assuring that children receive preventive health care may include enforcing immunization and health screening requirements, arranging for screenings, and helping families identify a source of ongoing health care or apply for Medicaid or a state insurance plan. Ways to achieve this goal are as follows:

Enabling local child care agencies to enrich children's programs with the comprehensive services required in Head Start:

Early childhood administrators can facilitate and support Head Start expansions or mergers with child care. Several of the mergers identified below have achieved an almost complete integration of Head Start and child care programs. These mergers assure that low-income

children who cannot enroll in Head Start can participate in a "seamless" child care/Head Start program and enjoy an enriched classroom curriculum, plus the comprehensive health and family services required by Head Start. Technical assistance and training have been especially important for success, and many administrative, staffing, reporting, and eligibility issues have been tackled.

Westchester Community Opportunity Program, Inc. (WestCOP) —Westchester County, New York

WestCOP is a community action agency that enrolls approximately 1,300 children in Head Start and 900 children in other child care programs. To provide comprehensive health services to all enrolled children, regardless of Head Start eligibility status, WestCOP collaborated with the county's social services department to develop a "Co-funding Memorandum of Understanding." This memorandum specifies that combined child care funding streams (such as Title IV-A and CCDBG) will cover child care expenses, while reallocated Head Start funds will support comprehensive family and health services for all enrolled children.

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Full Start: KCMC Child Development Corporation (KCMC) —Kansas City, Missouri

KCMC is the Head Start grantee in Kansas City, Missouri, responsible for a community partnership called Full Start. In this partnership, KCMC uses Head Start funds for Head Start-eligible children attending independent neighborhood child care centers, and the centers reallocate funds previously spent on these children toward comprehensive services for non–Head Start-eligible children at the centers. Center funders had agreed to continue full funding regardless of the amount of additional dollars received through Head Start. Private foundations, the United Way, the city government, and state day care entitlements also support the three Full Start pilot sites, covering 145 Head Start children and 150 other low-income children.

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United Neighborhood Houses of New York (UNH) —New York, New York

UNH and three of its member settlement houses in New York City have worked closely with the city's Agency for Child Development (ACD)—which manages child care funding—to merge the Head Start and day care programs co-located at the settlement houses. The new child development program combines separate educational, health, social services, accounting, food service, custodial, and other operations to save time and money and improve services for settlement families. At the beginning of the merger process, the gap in funding support and program requirements for health and social services was large: Head Start had full-time family and health assistants screening children and families and referring them to providers, while the day care program employed only a part-time nurse and had modest funds for mental health and social service consultants. So that comprehensive health and social services could be available for all of the children, ACD increased its financial support. UNH agreed to make continued resources available for strategic planning and negotiating systems change.

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Promoting partnerships between early childhood programs and local health departments:

Local health departments in many communities provide well-child care, immunizations, and dental care. Some provide primary care services. Many have a tradition of employing public health nurses familiar with community health services who can inform parents about eligibility for Medicaid, the Special Supplemental Food Program for Women, Infants, and Children (WIC), and EPSDT. However, while public health nurses can work with child care programs as health consultants and service providers, they are rarely available to child care agencies on an ongoing basis. To solve this problem, child care agencies serving children from low-income families have begun collaborating with municipal health departments in several communities to share the costs of assigning health department nurses to child care centers.

Columbus Metropolitan Area Community Action Organization (CAMACAO) —Columbus, Ohio

Many years ago, Columbus' Head Start grantee, CAMACAO, acknowledged that a collaboration with the Columbus Health Department (CHD) would be positive. The

collaboration involves a contract with CHD to provide a public health nurse to CAMACAO to oversee health services at Head Start centers. CAMACAO reimburses CHD for the nurse's salary. Every two weeks the nurse meets with her CHD supervisor to stay in touch with health department activities and policies. CAMACAO benefits from the continuing services of a well-connected and highly trained nurse who promotes the program's involvement with the greater health care community.

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Metropolitan Visiting Nurse Association (MVNA) Child Day Care Health Program—Minneapolis, Minnesota

Public health nurses in the Division of Public Health Nursing provide the Child Day Care Health Program with Minneapolis Health Department services. The nurses work through the MVNA to offer a range of public health services to about 119 licensed child care centers, including Head Start, and 600 family day care homes. Services include health consultation, individual education, and group training that assists child care workers in conducting appropriate health practices for the children in their care. Among other activities, nurses monitor the immunization status of almost 2,700 children, and they conduct educational programs for staff, parents, and preschool children.

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Seattle-King County Department of Public Health (SKCDPH) Child Care Health Program—Seattle, Washington

The Child Care Health Program, a program operating out of SKCDPH, employs 12 public health nurses plus 2.25 FTE nutritionists, one child health educator, and a .25 FTE psychologist to provide a range of services including health and safety promotion, to approximately 530 licensed child care centers in Seattle. The nurses monitor the collective health needs of children enrolled in child care in each neighborhood, and they assist child care providers with early identification and referral services for children who need further

evaluation and treatment. Two of these nurses oversee a combined health component for child care sites serving children enrolled in Head Start and the state prekindergarten program. This direct link to SKCDPH has increased the child care community's awareness of health services available in the city. The program's budget of over $1 million comes mostly from local tax dollars.[13]

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Goal B: Assure receipt of diagnosis and treatment

Few child care programs other than Head Start require providers to ensure that children receive treatment for medical problems and suspected disabilities. Head Start's performance standards call for programs to complete medical histories for all children, and to ensure that health problems detected during screenings and physical examinations are followed up with a definitive diagnosis and treatment. Health coordinators spend a considerable amount of time filling out forms and tracking down missing information from physicians.

In communities where health care resources are readily available, these coordinators do not have trouble arranging diagnostic tests and treatment for children, but this goal can be almost unreachable in medically underserved communities or in communities where many families lack health insurance. Some Head Start grantees and other comprehensive early childhood programs have developed solutions by negotiating cooperative agreements directly with health care providers. Their strategies are to broker arrangements for diagnosis and treatment services with providers, or to co-locate health services on the same site as child care services, or to provide case management services for children and families.

Brokering arrangements for medical diagnoses and treatment with single providers or groups of providers:

The health care needs of preschoolers are best met if the children receive comprehensive care on a continuing basis from a physician with hospital privileges who performs screenings and diagnosis, treats acute conditions, and refers the children to specialists when necessary. A child care center serving low-income children, in which the majority of children receive acute care in an emergency room, may wish to link up to a health care provider that can offer quality comprehensive services. This arrangement, often formalized in a memorandum of understanding, can facilitate information exchange between the health care and child care providers and

encourage relationships with ongoing sources of care while the children are in preschool. A major issue in these arrangements is how to finance health care for children not enrolled in Medicaid and not covered by other health insurance.

Decker Family Development Center (DFDC) —Barberton, Ohio

DFDC is a one-stop family support and early intervention program in Barberton, Ohio, which provides a wide range of services to both parents and their children. The program targets families with young children who are on public assistance. More than 75 percent are single parents with children. DFDC operates two Head Start classrooms and one developmental kindergarten classroom in collaboration with Barberton City Schools. DFDC also offers day care services to children 0–4 in collaboration with the University of Akron. Health services reach the children enrolled in DFDC, their siblings, and their parents (and even some DFDC staff) through a contract with the Children's Hospital Medical Center of Akron which calls for a full-time nurse practitioner and a physician to visit the child care center one day a week. The large volume of consultations requested thus far has encouraged the nurse practitioner to suggest that her services help keep children out of emergency rooms. Funding for the children's clinic comes from the Summit County Department of Human Services, limited Medicaid billings and the Ohio State Department of Education's core support for DFDC.

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Child Health and Disabilities Prevention Program —Orange County, California

In 1973, the Child Health and Disabilities Prevention program (CHDP) became law in California. This law made local health departments administratively responsible for implementing the federal EPSDT program for MediCal (California's Medicaid) recipients and also for implementing a similar program offering health assessments for low-income children not enrolled in Medicaid. In 1989 federal EPSDT reforms and new state funding for services strengthened both CHDP programs. California's Proposition 99 anti-smoking tax initiative was used to finance a new mandate to diagnose and treat conditions discovered during health assessments. In most counties, implementation of this new mandate was readily accomplished through the county hospital system. In Orange County, where there was no county hospital, the health department created a network of 150 private sector

physicians, community clinics, and private hospitals to meet the CHDP beneficiaries' needs. Children enrolled in Head Start and state preschool programs also became automatically eligible through CHDP for diagnostic and treatment services. The health department conducts outreach to both Head Start and state preschool programs in the county to encourage parents to take advantage of CHDP, and helps parents and children access services.

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Locating services on site:

In some communities, health clinics have been co-located with early childhood programs in a variety of arrangements. Community collaboratives have created multipurpose centers that house child care, health care, social services, and adult education. When co-location is combined with service integration, children in child care, and possibly their younger siblings, can enroll for health services at the same time. Prekindergarten or Head Start classrooms housed in elementary schools may have school-based health clinic services available to them, or Head Start programs and community health centers may occupy the same facilities. Unless the early childhood program and the health center actually work together and share information, however, co-location does not necessarily improve access for children to quality care.

New Jersey Head Start/Community Health Center Satellite Child Health Clinics —Statewide

The New Jersey Head Start State Collaboration Project, in consultation with Invest in Children, a child advocacy coalition, worked with state health agencies to establish two pilot satellite community health center (CHC) clinics at Head Start centers. These clinics offer complete preventive services and some primary health care. The CHCs provide the health care staff and handle Medicaid billing, and Head Start assists with intake, enrollment referrals to the local Medicaid agency, and helping parents and children keep appointments. Parents enrolling in Head Start choose the level of care they want to receive from the satellite clinics. These levels range from basic first aid and "school nurse" services to designating the CHC and its satellite clinic as a primary health care provider. If a family elects to have CHC and the clinic as the primary care provider, the satellite clinic becomes the site for well-child care and primary care, and follow-up care takes place at the CHC. Grants from the Prudential Foundation supported the remodeling of two satellite clinics and paid health provider salaries for the first year. Medicaid reimbursement supports continued clinic operations.

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Valeska Hinton Early Childhood Education Center —Peoria, Illinois

The Peoria, Illinois, Public Schools initiated a community collaborative process that resulted in the Valeska Hinton Early Childhood Education Center for preschool through first-grade children and their families. Two of the preschool classrooms are Head Start, and two are a part of the Illinois state Star preschool program. Health services for enrolled children consist primarily of health screenings and acute care for minor ailments provided by a nurse practitioner who also organizes health fairs for screenings and physicals (through Project Success) for district children about to enter school. The nurse practitioner works at the school and receives professional supervision and medical backup from a family practice physician. Some of these services are funded through Medicaid and some through Title 1.

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Providing case management services to children and families:

Case management refers to activities that help clients meet basic needs in the areas of health care, housing, education, and transportation.* A case manager assesses needs, creates an action plan, arranges for services, and ensures that services are delivered. Professional case managers work in many settings, including hospitals, health clinics, welfare agencies, and comprehensive service programs. They usually do not provide direct services, but rather offer information, advice, and emotional support tailored to individuals and families with the objective of improving family competencies and functioning. In the case of low-income children without severe disabilities, case management can promote health and improve access to care so that suspected chronic problems or developmental delays are detected and treated. Child care programs cannot offer intensive case management services, however, without a continuing financing mechanism and an appropriate staffing structure.

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* See series of resource briefs published in July 1995 by the National Center for Children in Poverty: *Who Are Case Managers and What Do They Do? Case Management in Service Integration*; *Working with Clients: Case Management in service Integration*; *Preparation, Staff Development, and Supervision of Case Managers*; *Managing Case Managers: Case Management in Service Integration,* (Ellen L. Marks and Carolyn Marzke, authors).

States may elect to use Medicaid as a flexible source of financing for case management for young children if state matching funds can be identified, but specific mechanisms and service system arrangements usually require extensive negotiations among several agencies. Child care providers usually do not have the option of obtaining reimbursement unless they are part of other statewide initiatives. Specific Medicaid options for case management available to child care providers include EPSDT, administrative case management, and optional targeted case management.

Maine Head Start and Medicaid Administrative Case Management —Statewide

After a long and complex process, all of Maine's 13 Head Start programs became Medicaid-billable EPSDT providers using administrative case management. The state of Maine, which supplements federal Head Start funds, was able to use the supplement as a state Medicaid match. Covered services include Medicaid eligibility determination; coordination of health screening, examinations, and evaluations; arranging for immunizations, health education; and others. The use of Medicaid funds helps to free up other federal and state dollars previously set aside for health component activities.

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Goal C: Assist parents in obtaining health-related benefits

Children enrolled in publicly funded early childhood programs may be eligible for Medicaid or other state-funded insurance programs. If they are enrolled in Medicaid, they are automatically eligible for the EPSDT program, which assures treatment for conditions uncovered during an EPSDT examination. In communities where managed care programs are enrolling Medicaid recipients, children can benefit from the network of specialists and services they offer, although special authorization is sometimes needed for certain services. Unfortunately, however, too many low-income children are not enrolled in the programs for which they are eligible. Early childhood programs can help parents apply for Medicaid or other state health insurance plans, and can then advocate for them if the parents encounter barriers. Head Start has begun to emphasize Medicaid enrollment as part of a family assessment process conducted at the beginning of each school year.

New Jersey Head Start Medicaid Outreach —Statewide

Strategies to encourage Head Start and Medicaid collaboration emerged from a health task force of the New Jersey Head Start Collaboration Project. The initial rationale was to inform the Head Start community about recent changes in Medicaid eligibility (OBRA, 1989), and to give Head Start staff the knowledge and skills to screen Head Start children for Medicaid eligibility. As a result, a series of training sessions were organized for Head Start directors and health and social services coordinators. In addition, Invest in Children, a coalition of corporations and advocacy groups administered by the Association for Children of New Jersey (ACNJ) helped secure funding from the Hite Foundation to support a county-based planning strategy. These efforts involved running five sessions for Medicaid officials from 20 of New Jersey's 21 counties leading to 20 local agreements drafted between Head Start and the local Medicaid agency. Although a final evaluation of these efforts has not been made, increases in Medicaid enrollment of Head Start children statewide were reported in the two years following the project.

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New York WestCOP —Westchester County, New York

WestCOP, described also on page 13, is the county's largest child care and Head Start grantee. It enrolls more than 2,000 children in 23 centers. WestCOP works with the county Department of Social Services, which administers several child care funding programs, to blend Head Start and child care funding streams with private donations and grant support, thereby offering comprehensive services to all enrolled low-income children. If the family income is too high for the family to qualify for Medicaid, workers tell them about Child Health Plus, a New York State insurance program for children that covers preventive services and acute care. Administrative staff train health and social service workers to help parents fill out Medicaid forms, call the toll-free Child Health Plus numbers, and obtain enrollment forms from nearby health centers.

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Linking Child Care and Child Health in the New Policy Environment

The local health care/early childhood collaborations profiled here employ several strategies to meet one or more child health goals. These goals range from assuring health and safety to improving access to health care for young children in the community.

Health care and early childhood program administrators at the federal and state level can systematically support and encourage local programs to pursue the following objectives:

- To meet the national child care health and safety standards endorsed by the American Academy of Pediatrics and the American Public Health Association.
- To assure that children receive preventive health care services recommended for their age.
- To document that children receive diagnostic and treatment services for conditions identified in preventive screenings.
- To assist parents in obtaining health-related benefits to which they are entitled.
- To link parents and their children to "a medical home"—a source of ongoing comprehensive quality health care.
- To advocate for the creation and expansion of health care services for children in child care—as well as for younger siblings and children in the same neighborhood.

While many early childhood programs, including Head Start, have made progress in achieving one or more of the goals, the majority of early childhood programs cannot play a more proactive health promotion role without information and technical assistance. In addition, changes may also be necessary in a state's policy environment of regulations, resources, and mechanisms, to help facilitate linkages between early childhood programs and health care systems. Both state and local health and child care agencies are critical to making these linkages happen.

Profound changes in health care delivery and the reconfiguration of some early childhood programs, coupled with fiscal and political pressures to maximize public resources for poor children, are likely to create new opportunities as well as challenges for improving service systems for preschoolers. For example, the 1990 Child Care Development Block Grant heightened attention to health and safety needs of preschoolers. On the health side, many states are obtaining demonstration waivers to transform Medicaid into managed care and to expand access for uninsured groups. Under these conditions, early childhood programs could

increasingly be a route to spurring communitywide solutions to health care problems of preschoolers and a vehicle to reach children who need to be linked to medical homes and health care services.

Federal initiatives to consolidate programs, increase state autonomy, and cut levels of funding will further change the environment for early childhood programs and health systems in ways that cannot be fully anticipated at this time. Some state plans to reform welfare, for example, would further limit child care subsidies currently available to low-income families. Some states may begin to deny AFDC cash assistance for some subpopulations, and block grant funding would call for new procedures to inform families about new Medicaid rules and enroll them. Also, changes in federal early childhood legislation is likely to encourage states not only to turn to local communities for basic service decisions, but to decrease state oversight.

These likely cuts and changes in benefit packages, plus dramatic increases in the enrollment of low-income families in managed care, will affect not only the health status of low-income preschoolers but the mix of barriers and opportunities to link child care and child health. They will also require different monitoring and other strategies from families as well as the early childhood and child health communities. Nationally, for example, managed care plans now enroll more than half of all AFDC recipients and a fourth of all Medicaid recipients.[14] Low-income families may find that the new system alters existing barriers, creates new ones, or creates new opportunities, whether or not their children are enrolled in Medicaid. For example, funding shifts and Medicaid cutbacks may force certain providers to relocate or reduce services for families who are not eligible for Medicaid, such as illegal immigrants and the working poor.

Child advocates and child health professionals also have concerns that state contracts with managed care programs may not guarantee comprehensive preventive health screenings (EPSDT) for Medicaid-eligible children, and immunization coverage of infants and toddlers is not assured.[15] Many plans do not have an adequate supply of primary care physicians who are accessible to the enrolled population, and the plans may not offer other supportive services that low-income families need to make and keep appointments or manage chronic health problems.

In response to such concerns about ongoing state health care reforms, many local programs serving young children in low-income families will need to find new ways to help them access health care services and make sure that their preventive health needs are met. In anticipation of this need NCCP has sought examples of community-based early childhood programs to illustrate a variety of approaches for meeting child health needs. The case examples described in this paper suggest new program strategies that might be pursued by state and local child care and health care agencies as health care and welfare reforms are implemented.

State and health and early childhood leaders can work together to meet child health goals by strengthening the capacities of local early childhood programs to link families and children to health care services. They may wish to adopt several strategies, depending on the resources available at the state and community level. The table on pages 26 and 27 lays out a possible framework for thinking about goals, objectives, and implementation strategies. It suggests specific steps drawn from the programs described in this paper and elsewhere. As the early childhood and child health communities learn more about the implications of federal and state policy changes for low-income families with young children, they may find that different parts of the framework assume more or less urgency and feasibility.

By enlisting public and private health agencies as partners, early childhood programs can become community resources as well as community advocates for improving the health of very young children. As a first step, they will need to better understand how a rapidly changing health care system could affect children, families, and communities. An expanded role in child health for early childhood programs will increasingly be needed in a future in which low-income mothers of young children are more likely to be working or enrolled in training programs, in which managed health care arrangements will be the norm, and in which states have a more prominent role in assuring access to health care.

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Child health goals and potential implementation strategies for health and early childhood programs

Child health goals	Objectives for program administrators	Potential implementation strategies
1. Meet national child care health and safety standards	• Help child care providers meet licensing requirements for health and safety • Assist providers in developing written health policies • Help to improve training for child care staff in health and safety practices	• Expand and improve child care licensing and monitoring efforts • Provide funds to resource and referral agencies or local child care administrative agencies to provide training and technical assistance to child care programs on health and safety • Encourage child care grantees to negotiate an in-kind or contractual agreement with a health consultant from their community • Target funds to grantees for training or hiring a designated staff member as a health and safety "specialist"
2. Assure receipt of preventive health care	• Tighten enforcement of immunization and screening requirements for all children at entry into child care • Promote the role of child care agencies in providing outreach, enrollment assistance, and guidance to help parents negotiate the health care system • Explore financing for services and/or staff to assure services for ALL children in child care	• Make health screenings and immunizations a condition of funding • Utilize funds for improved child care licensing and monitoring efforts • Facilitate and support Head Start expansions or mergers with other child care programs • Promote partnerships between early childhood programs and local health departments • Promote local cooperative agreements with managed care plans that serve a large number of children in child care • Advocate at the state level for contract language requiring managed care plans to assure the delivery of preventive health care to all enrolled children • Negotiate with other state agencies to obtain Medicaid reimbursement for EPSDT case management services provided by child care programs
3. Assure receipt of diagnosis and needed treatment for conditions identified during screenings	• Promote the role of child care providers in assuring diagnosis and treatment • Provide training and technical assistance to child care providers on strategies to assure diagnosis and treatment	• Make diagnosis and treatment assurance a condition of funding • Provide funds to hire or train staff responsible for assuring diagnosis and treatment • Promote partnerships between early childhood programs and health providers (public and private) • Encourage the development of on-site health care arrangements in child care programs • Negotiate with other state agencies to obtain Medicaid reimbursement for EPSDT case management and treatment services provided by child care programs

Child health goals, *continued*

Child health goals	Objectives for program administrators	Potential implementation strategies
4. Assist parents in obtaining health-related benefits	• Promote the role of child care providers in assisting parents to apply for Medicaid, WIC, EPSDT, and state health insurance for their children • Encourage efforts by child care providers to educate parents about how to access health care benefits for their children	• Offer small contracts to child care providers for assisting parents to obtain health-related benefits • Facilitate cooperative arrangements between local agencies administering Medicaid, WIC, or other health programs, and child care programs, to assist in educating and enrolling families • Negotiate with other state agencies to obtain Medicaid reimbursement for EPSDT case management services, including outreach, provided by child care programs • Work with other agencies to develop a common application for Head Start, WIC, Medicaid, and other subsidized child care programs
5. Link parents and their children to a medical "home"—a source of ongoing and comprehensive quality health care	• Foster the role of child care programs in helping families find a medical home • Provide the necessary training and technical assistance required to enable child care programs to effectively link families to a medical home	• Provide funds for training and technical assistance for child care providers to help link families to a medical "home" • Offer small grants to establish community-wide managed care liaisons for early childhood programs • Collaborate with other agencies to address health service delivery gaps and specific provider shortages • Encourage collaboration with health providers to establish satellite clinics at child care programs and/or elementary schools
6. Advocate for the creation and expansion of health care services for children in child care—as well as for younger siblings and other children in the neighborhood	• Advocate for the integration of child care with health care services in all early childhood programs • Help assure that health care services are available to all children in the community, regardless of current enrollment in child care	• Provide funds to child care programs to create and/or enhance their health component • Promote community collaborations which not only provide comprehensive health services to children in early childhood programs, but also provide services to younger siblings and other children in the community