



National Advisory Committee On Rural Health and Human Services



Challenges to Head Start and Early Childhood Development Programs in Rural Communities

Policy Brief December 2012

RECOMMENDATIONS

- 1. The Committee recommends that the Secretary work with Congress to increase collaboration between rural Head Start grantees and other federal programs on transportation.*
- 2. The Committee recommends that the Secretary work with Congress to pursue a temporary compliance waiver for grantees in good standing who meet a specified definition for rural and are located in a dental or mental health HPSA when their communities lose access to a sole dental health or mental health provider.*

INTRODUCTION

Early childhood programs are important for assisting low-income children with a broad range of concerns, such as child care, health care screening and early educational development. The United States Department of Health and Human Services (HHS) administers a number of programs to serve low-income children such as Head Start and the Child Care and Development Fund (CCDF). In 2007, the Committee examined the unique challenges faced by rural Head Start programs and provided several recommendations. Our site visit to Ottawa, Kansas during the June field meeting revealed that many of the challenges highlighted in our 2007 report still exist, both for Head Start and other programs.

As was true in our earlier report,¹ serving this population poses a particular challenge in rural areas, which are “likely to have disproportionately high child poverty: 81 percent of counties with persistent child poverty are nonmetropolitan while only 65 percent of all U.S. counties are nonmetropolitan.”² Additionally, rural providers often struggle to create the economies of scale that enable them to provide services efficiently. This paper seeks to address the regulatory challenges to providing quality early childhood services in rural communities.

BACKGROUND

HEAD START

¹ National Advisory Committee on Rural Health and Human Services. *The 2007 NACRHHS Report*. “Head Start in Rural Communities.” 2007. Pg. 17.

² Mattingly, M.J., Johnson, K.M., and Schaffer, A. *More Poor Kids in More Poor Places: Children Increasingly Live Where Poverty Persists*. The Carsey Institute, University of New Hampshire. Fall 2011. Issue 38. Pg. 1.

Head Start is an early childhood program created in 1964 to meet the developmental needs of low-income children ages birth to five. The program is administered by HHS through the Administration of Children and Families (ACF). Federal funds are provided directly to local grantees rather than to states. Children are eligible to participate in Head Start if they come from a low-income family, as 90% of Head Start's enrollment must be at or below the federal poverty guideline. Head Start service delivery varies greatly across the country (e.g. center-based, home-based, combination), but the program strongly emphasizes the involvement of both the parents and the community. The Committee chose to revisit the topic of Head Start in rural communities because it remains the "only early childhood program specifically designed for low-income children and families."³

CHILD CARE DEVELOPMENT FUND

Authorized in 1990, CCDF is a federal program that provides families with subsidies for child care for children below thirteen years of age while actively working to improve the quality of child care. Specifically, CCDF seeks to enable low-income parents and Temporary Assistance for Needy Families (TANF) recipients to work or to participate in education or training programs by providing care for their children. The federal government allocates funds directly to eligible states and tribes through block grants, which they use to administer CCDF services and programs. Block grants give states and tribes broad discretion in program design and regulation. In particular, the states and tribes are responsible for establishing eligibility of families for the subsidy program, as well as for coordinating CCDF program activities with federal, state, and local child care and other early childhood development programs, such as Head Start.

Because they lack economies of scale, rural communities may be an ideal place to provide more comprehensive early childhood services to small populations by integrating Head Start and CCDF services. Many rural communities could benefit from coordinating these two programs to help expand and increase services to more children, but true collaboration faces considerable regulatory challenges regarding eligibility criteria, application cycles, and group size/ratio limits.

DISCUSSION AND RECOMMENDATIONS

The Administration has put a priority on developing more place-based policies, which "can influence how rural and metropolitan areas develop, how well they function as places to live, work, operate a business, preserve heritage, and more."⁴ The Committee believes that approach is a particularly good fit for rural communities, "since rural places face particular challenges related to scale (due to fewer people and greater distances), but advantages related to integration (due to relationships built among a small set of local stakeholders)."⁵ Throughout its work on this topic, the Committee observed a distinct need for place-based policies regarding early childhood services in rural communities. The small rural population size severely limits the financial flexibility of these programs while geographical and access-related challenges stress grantees' resources even further.

³ National Advisory Committee on Rural Health and Human Services. *The 2007 NACRHHS Report*. "Head Start in Rural Communities." 2007. Pg. 17.

⁴ Mueller, K.J., Clinton MacKinney, A., Gutierrez, M., and Richgels, J. *Place-based Policies and Public Health: The Road to Healthy Rural People and Places*. Rural Policy Research Institute. March 2011. Pp 3.

⁵ *Ibid.* p. 3.

Given the continuing challenges posed by transportation, the Committee returns to its 2007 recommendation to increase investment in transportation. Transportation continues to be a significant barrier for rural Head Start programs, as it was in 2007. Remote rural grantees struggle to meet Head Start Program Performance Standards (HSPPS) due to the logistics surrounding transportation to the program itself, as well as required medical, dental, and mental health appointments for enrolled children. Absent an increase in funding, the Office of Head Start (OHS) does not currently have additional funds to provide to grantees for transportation. It is the responsibility of each local program to determine the priorities for providing services to children and families while remaining compliant with standards and regulations—a responsibility that is greatly complicated by distance for rural grantees. While the 2007 Head Start ACT affords local grantees the option of requesting a reduction in enrollment, in order to allocate funds elsewhere, such as transportation, the Committee believes that serving fewer children in rural areas is not the answer to the transportation question.

BEST PRACTICES IN RURAL COLLABORATION

The Head Start grantee in Coffeyville, KS has benefited greatly from collaboration with the Federally Qualified Health Center (FQHC) in its community. The FQHC's ambulatory unit reduces some problems that arise in transporting enrolled children to medical appointments and its portable dental equipment has been critical in meeting HSPPS requirements for dental health. The Head Start director explicitly stated that the FQHC was the difference between compliance and noncompliance with HSPPS for her program. The Committee was encouraged by the seamless collaboration between these two federal programs and encourages the Secretary to look into ways to further develop such collaboration in other rural communities.

The Committee recommends that the Secretary work with Congress to increase collaboration between rural Head Start grantees and other federal programs to assist rural providers on transportation issues. Such collaboration would better leverage federal resources to ensure that rural Head Start programs are not forced to reduce the services available for children who already face disparate access to early childhood resources. This may be an ideal issue for the White House Rural Council to address.

The Committee is also concerned about meeting the specialized needs of children in underserved areas. Nonmetropolitan counties comprise sixty-one percent of dental health HPSAs and fifty-seven percent of all mental health HPSAs.⁶ The Kansan providers the committee met with noted that many rural dentists do not offer services to young children or do not accept Medicaid, reconfirming the results of our 2007 report on the same topic. The dearth of providers for these services makes it highly difficult for rural Head Start grantees to meet HSPPS for dental and mental health, putting them in danger of losing their funding due to noncompliance. Currently, HHS does not have the authority to provide a waiver for mental health and dental services but OHS does take into account special circumstances such as a lack of providers when assessing program compliance.

⁶ *Designated Health Professional Shortage Areas (HPSA) Statistics*. Office of Shortage Designation, Bureau of Health Professions Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services. Updated July 15, 2012.

The Committee recommends that in future re-authorization of the Head Start program the Secretary work with Congress to provide a formal waiver temporary compliance waiver for grantees in good standing who cannot find a qualified mental or dental health provider due to being located in a dental or mental health HPSA. The waiver would apply only to existing programs that were previously compliant with HSPPS and would prevent the grantee from losing funding and thus disrupting a critical service for children in the community as long as they could show a good-faith effort in recruiting to fill that need.

A waiver provides a higher level of certainty for rural grantees—currently their program compliance is handled on a year-to-year basis that requires a detailed consideration of local provider availability and other factors. Under a waiver, these grantees would have a formalized option that does not leave them at risk for factors beyond their control. The Committee also believes that the expansion of community health centers and the focus on expanding oral and mental health services among these providers may offer other opportunities for collaboration with Head Start programs. The Committee saw this first hand during its site visit.

Additionally, the Committee continues to be concerned about additional program compliance issues for low-volume Head Start grantees. HHS may want to consider providing additional flexibility in determining compliance for programs with fewer than 10 enrolled children. While OHS does account for the size of each grantees program, this concern was raised by grantees in Kansas.

Professional development poses a significant challenge for rural early childhood service providers in Head Start and CCDF. Many CCDF supported child care providers do not have access to the same training resources as their counterparts in Head Start programs. The Committee suggests that Head Start programs allow local CCDF providers to access training resources such as the Head Start Centers of Excellence to help with professional development.

The Committee recognizes that the work of the Office of the Deputy Assistant Secretary for Early Childhood Development is in accord with this recommendation. OHS continues to work with the Office of Child Care (OCC) on a variety of strategies to raise the level of quality programs available to all families served, including those in rural populations.

However, rural Head Start grantees noted significant difficulty in complying with the HSPPS requirement to have a credentialed staff at all times to ensure that the pre-school preparation meets quality standards. Grantees are required to have a variety of different credentials among their staff, including a Bachelor of Arts (BA) in Early Childhood Education, a Child Development Associate (CDA), and an Associate of Arts (AA) in Early Childhood Development, while for Early Head Start, a CDA is required upon hiring.⁷ Additionally, lack of internet service affects grantees' abilities to access online professional development opportunities which could help them meet the requirements of the Head Start Act and regulations. Grantees voiced frustration at the dearth of professional development options available with limited internet access.

⁷ *Head Start Act* 42 U.S.C. § 9843a . “Staff Qualifications and Professional Development.” 2007.

Many grantees in on the committee's site visit to Ottawa, KS explained that while they hire new employees and provide funding to get them credentialed, the employees often leave for better paying positions in more metropolitan areas once licensed. Grantees lack the means to enforce the employees' statutory obligations of three years' service after receiving training funded by Head Start. In best case scenarios, grantees convince employees to pay back the cost of the credential, but often the program simply absorbs the financial cost and remains out of compliance.

While the authority to enforce the statutory service requirement for Head Start employees who receive financial help with professional development lies with the grantees themselves and not with ACF, the lack of resources tends to prevent any enforcement at all. The Committee urges HHS to provide additional technical assistance to grantees on this issue to better understand their legal rights and options for addressing these situations.

Finally, the Committee believes that smaller rural communities would greatly benefit from coordinating Head Start programs with Child Care Development Block Grant services (CCDF) to create more comprehensive services. The Committee recognizes that the two programs are different, but in the area of child care services rural providers in both programs face similar problems due to small numbers and limited infrastructure. However, the Committee acknowledges the challenges of federalism—coordinating these two programs can be difficult. States and tribes have considerable discretion in CCDF funding while HHS sets specific guidelines for Head Start. The Committee encourages ACF to explore ways to align Head Start and CCDF programs, particularly to reduce the regulatory burden on small rural providers of child care services.

Administrative funding streams and eligibility criteria are two key parts of the programs that do not always align well. Grantees expressed concerns over the administrative burden of reporting for both programs and the conflicting regulations surrounding eligibility criterion, application cycles, and group size/ratio limits that currently inhibit collaboration.

Criteria related to parental employment status becomes an issue because Head Start has no employment standard for parents while CCDF requires that the parents of enrolled children be either working or participating in career training or continued education.⁸ Additionally, the two programs approach income eligibility differently. While 90 percent of the children that Head Start serves must fall below the federal poverty level, CCDF serves families earning “less than 85 percent of the state median income.”⁹ Families enrolled in Early Head Start remain eligible for the duration of their enrollment, but review cycles for CCDF eligibility range from 6 months to 12 months and are individually set by the states.¹⁰ These complications leave many Head Start children ineligible for CCDF services based on parental employment status, or vice versa

⁸ Del Grosso, P., Akers, L., & Heinkel, L. *Building Partnerships between Early Head Start Grantees and Family Child Care Providers: Lessons Learned from the Early Head Start for Family Child Care Project*. 12 December 2011. Mathematica Policy Research.

⁹ Flynn, M. & Hayes, C.D. *Blending and Braiding Funds to Support Early Childhood Education Initiatives*. January 2003. The Finance Project.

¹⁰ Del Grosso, et al. *Building Partnerships between Early Head Start*, p. 41.

due intensive Head Start standards that do align with CCDF. This compliance struggle may discourage Head Start programs from collaborating with CCDF child care providers.

CONCLUSION

The Committee suggests that HHS work with Congress in the next re-authorization to provide formal demonstration authority. This new authority could support a rural-focused demonstration in which rural applicants with low-volume populations could coordinate CCDF and Head Start services with appropriately relaxed performance reporting to examine whether this administrative flexibility could improve child development outcomes for rural populations. This demonstration would build on the OHS/OCC Recovery Act-funded demonstration called “An Early Head Start for Family Child Care,” in which 22 communities used consultants placed with Early Head Start providers to increase professional development, comprehensive services, and overall quality in family child care homes in the surrounding neighborhoods. Increasing family child care provides a potential solution to rural child care challenges—both the shortages of child care in rural areas, as well as the transportation difficulties created by a large center that serves multiple counties. Wrapping Head Start and CCDF funding into family child care would expand child care option for low-income rural families. By removing some of these barriers for a small sample of rural providers, HHS would be able to fully assess the impact that collaborative programming has on a rural community.

Rural early childhood services provide vital developmental opportunities to children who would otherwise face very constrained options. The Committee believes that enabling those rural programs to maintain the same standards as their urban counterparts is a critical component to serving rural communities. In this vein, the Committee encourages the Secretary to explore ways to better link HHS programs that focus on children to avoid programmatic “silos” where children do not easily transition from one program to the next as they age. We believe this is an important step towards a “no wrong door” policy in rural human services, where more children demonstrate more need.