Head Start Health Managers Descriptive Study

Supporting Statement Part A
For OMB Approval

March 6, 2012
Updated: November 2012

A. Justification

The Administration for Children and Families (ACF) of the Department of Health and Human Services (DHHS) is requesting Office of Management and Budget (OMB) clearance for the Head Start Health Managers Descriptive Study. In referencing "Head Start programs" throughout this document, all Early Head Start and Head Start programs, including Migrant and Seasonal and American Indian and Alaska Native programs are included.

A.1. Circumstances Making the Collection of Information Necessary

A.1.1. Overview of Request

The Administration for Children and Families (ACF) has contracted with the RAND Corporation to collect descriptive information on the health services area of Head Start, a core component of Early Head Start and Head Start programs. This section provides an overview of the study and discusses its objectives and the need for the proposed information collection.

The Head Start Health Managers Descriptive Study will collect information from the universe of health managers at the grantee and delegate level to provide information, currently not available in any other source, about the breadth and depth of health-related activities offered to children and families participating in Head Start. By systematically collecting a common core of information about the health services area for all Head Start programs, the study will provide critical insight into how health-related activities vary by well-defined program characteristics such as locality (urban/rural), cultural and language preferences of the population served (paying particular attention to Head Start Migrant and Seasonal and American Indian Alaska Native programs), and program option (home- and center-based). By collecting information on the health services area for all Head Start programs, the study will accurately represent the full range of health programming offered in Head Start programs, programming that is expected to be extremely varied given the differences in the health needs of the populations served across Head Start programs combined with variation in the health-related resources and other aspects of the community environments within which Head Start programs operate. In addition to examining the services provided, the study also will provide information about the staffing structure of the health services component, an area about which there is currently little information. The study will fully capture variation in program services, staffing structure, and the associated opportunities and challenges programs face and will support analyses that examine other variation in the health services area between subgroups defined by these measures. Such subgroups will include the type of Head Start program model, urban versus rural location, demographics of the population of participating families and children, as well as subgroups that are assumed to emerge as part of the descriptive analysis including subgroups defined by the staffing model for the health services area, the organizational model for the Health Services Advisory Committee, or by the nature of the relationships with community-based partners. As no data currently exists on many of the potentially important grouping variables (for example, the health services area staffing, program services, or Health Services Advisory Committee), no sampling frame could be created that would adequately reflect these variables. Thus, a census survey is proposed which will allow for analysis of these subgroup and thereby increase the usefulness of the data to the Office of Head Start as it plans for technical assistance and program guidance.

The legislative basis for the Head Start Health Manager Study is the Improving Head Start for School Readiness Act of 2007 (P.L. 110-134). Sec. 649 of the Act (included in Appendix A) outlines

requirements for the Secretary to "carry out a continuing program of research, demonstrations, and evaluation activities to…foster continuous improvement in the quality of the Head Start programs… and in their effectiveness in enabling participating children and their families to succeed in school…" (Sec. 649 (a) (1)). Among the specific objectives for the research program, two in particular relate to the health services area, namely "to identify successful strategies that promote good oral health and provide effective linkages to quality dental services through pediatric dental referral networks…" and "to identify successful strategies that promote good vision health through vision screenings…" (Sec. 649, (d) (5) (A)-(B)).

A.1.2 Study Context and Rationale

The Head Start program was created in 1965 and delivers early education and support services to low-income children ages three to five and their families. In 1995, Early Head Start was initiated to provide a similar program of services to infants, toddlers, pregnant women, and their families. Migrant and Seasonal Head Start programs serve children of low-income migrant or seasonal farm workers. These programs typically run during the summer months and the majority of children are dual language learners. Early Head Start and Head Start programs serving American Indian and Alaska Native children incorporate their unique history, community traditions and beliefs into their program's operation, and provide an integration of language and culture into the delivery of services to children and families. As of the 2010-2011 program year, Head Start had 2,313 grantees and an additional 557 delegate agencies (agencies contracted by grantees to deliver Head Start programs). Together the grantees and delegate agencies serve just over 1,000,000[1] children and pregnant women annually. 36.8% of Head Start children served are identified as Hispanic or Latino (36%), while 28.5% are identified as African American (30%).[2]

Head Start was an important initiative of the War on Poverty in the 1960s, fulfilling a need for a comprehensive and holistic preschool program for children at socioeconomic disadvantage: one that would promote social and behavioral competence, ensuring that disadvantaged children enter school with a similar foundation as their more economically advantaged peers. Since the inception of Head Start, there has been broad recognition that the optimal development of such competencies requires maximum health across all domains. As a result, health was, and remains to this day, a core feature of Head Start programs. Indeed, promoting a child's physical development and health is one of the featured domains in the *Head Start Child Development and Early Learning Framework*, signaling the importance of child health in promoting optimal development leading to school readiness.[3]

To assist each child in attaining their greatest possible physical, emotional, cognitive and social development, Early Head Start and Head Start programs are regulated at the Federal level through Performance Standards (45 CFR 1301-1311).[4] The **child health and developmental services** (45 CFR 1304.20) require: a determination of current health status; screening for developmental, sensory, and behavioral concerns; facilitating follow-up and treatment by providing assistance to families who

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1 This number is the cumulative number of children and pregnant women served in the program year.

2 Head Start Program Information Report (PIR) 2010-2011

3 Department of Health and Human Services. *Head Start Child Development and Early Learning Framework.* 2010. http://transition.acf.hhs.gov/programs/ohs/resource/hs-child-development-early-learning-framework

4 Department of Health and Human Services. *Head Start Program Performance Standards 45 CFR Chapter XIII*. 2009. http://eclkc.ohs.acf.hhs.gov/hslc/standards/Head%20Start%20Requirements/45%20CFR%20Chapter%20XIII

require assistance seeking and/or paying for care and managing their child's health condition; implementing procedures to ensure ongoing and routine care and preventive services; educating and involving parents in all decisions related to their child's health; and individualizing the program to maximally support each child, based on their strengths and special needs. The **child health and safety** performance standards (CFR 1304.22) specify requirements on emergency procedures, hygiene, medication administration, and injury prevention. CFR 1304.23 outlines **child nutrition** requirements including identification of nutritional needs, provision of nutritional services, food safety and sanitation, and educating and developing relevant skills for families around nutrition and healthy food preparation). CFR 1304.24 specifies requirements on **child mental health** including working collaboratively with parents to identify child mental health concerns and appropriate courses of action; securing the services of mental health professionals; and the provision of regular, on-site mental health consultation.

To provide these services, every Head Start program is required to have at a minimum one **health manager** responsible for managing, facilitating and coordinating health services (including selecting providers and negotiating payments) that promote child health. Nutrition and mental health services must be supported by either staff or consultants. In addition, the health manager supervises other Head Start staff as they perform health-related duties, and is responsible for maintaining, monitoring, tracking, overseeing and assuring the confidentiality of health records. Although health managers are required to have training and experience in health, they may or may not provide direct services, depending on the size and staffing model of the program. They directly supervise health staff and other consultants that may support the program in the areas of nutrition and/or mental health

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

Although specific in their requirements, the Performance Standards in the Health Services Area are not overly prescriptive with respect to how such requirements are to be implemented. For example, the standards require "screening for developmental, sensory, and behavioral concerns." However, the standards do not indicate the specific developmental, sensory, or behavioral health areas that programs must provide screening for, nor do they dictate whether those screening services are to be provided onsite or offsite or specify who should conduct that screening. Likewise, other aspects of the performance standards are not specific about the exact services to be provided, who should provide them, the context in which they are to be provided, the mechanisms for ensuring parent involvement, and the approaches to engaging community partners. As a result, Head Start health managers have significant flexibility to focus on health issues that are priorities for their population, and to implement them in a way that maximizes center and community resources within the framework and constraints of their internal organization and operating structure.

With this flexibility, however, comes the challenge of understanding the breadth and depth of health services within Head Start programs and how the staffing structure and community resources

supports the health services area. As discussed in more detail in the sections that follow, this study seeks to gain that understanding by collecting much needed data for a critical component of the Head Start program that is otherwise not available in any other source.

The study is guided by a conceptual framework that is shaped by an understanding of the key stakeholders involved in planning for, implementing, and participating in the health services area, as well as the Head Start Performance Standards in the health services area (see Exhibit A.1.1). As shown on the left side of the framework, at the center of the health services area is the health manager and other program staff (e.g., teachers, family service workers, home visitors, and other program managers such as the program director) who plan for and implement the health component. The core health-related Head Start staff interact with four other key sets of stakeholders: the Health Services Advisory Committee, the parents and families of participating children, the health care providers in the local community, and other local community members and service providers. The arrows in the figure further convey that there are interactions between all the stakeholder groups, in addition to those facilitated by the Head Start program.

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

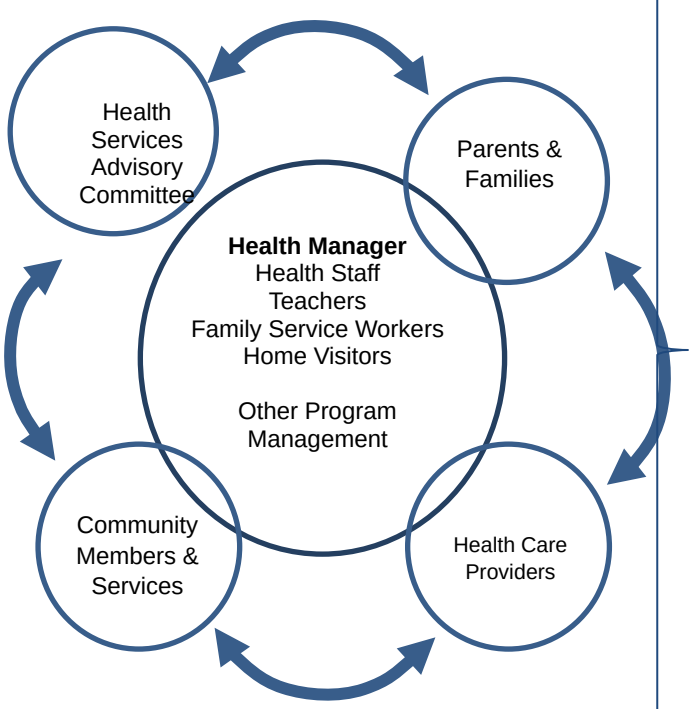
The framework in Exhibit A.1.1 provides a mechanism by which to conceptualize the wide-ranging components and activities of the Head Start health services area. Although each program is likely to conduct at least some activities related to each aspect, or level, of the framework, we expect the relative emphasis to vary significantly by program based on the needs of the population served and the available internal and external resources. However, the extent of that variation is currently unknown. The information collected for the study will support a richer understanding of the full range of strategies employed by Head Start programs in the health services area, the ways in which programs are meeting with success, and the issues that are challenging to address. Such insights, coupled with detailed information on programmatic features and policy levers that exist to support such services, will provide a wealth of information for the Office of Head Start. The resulting data will help to shape technical assistance to promote the health of Head Start children and families, inform decisions about programmatic improvement, and identify information gaps to be addressed in future data collection efforts.

A.2. Purpose and Use of the Information Collection

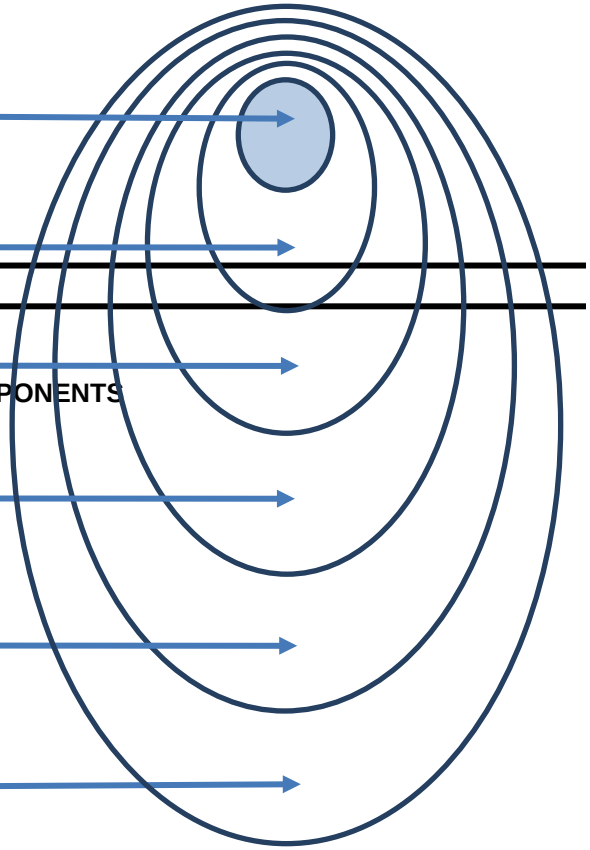
The purpose of the Head Start Health Managers Descriptive Study is to provide a current snapshot of health-related activities and programming within Head Start programs, to better understand the context in which the Head Start health services area operates and to identify the current needs of health managers and health staff as they work towards improving the health of Head Start children,

Exhibit A.1.1 Head Start Health Managers Descriptive Stu… …k

KEY STAKEHOLDERS *(Modules 1-7)* **HEA… …OMPONENTS**



- Health management of individual child *(Module 2)*
- Screening, referral and health services provided *(Module 3)*
- Prevention and promotion activities *(Module 4)*
- Staff wellness *(Module 5)*
- Broader community linkages *(Module 6)*
- Administrative context *(Modules 2-5 as applicable)*



parents, and staff. Given this motivation, this study is descriptive; it is not designed to capture individual child or family health-related outcomes or the attainment of specific health-related performance standards. Data from this study will not be used for monitoring purposes. Instead this study will provide the Office of Head Start with a full understanding of what Head Start programs are doing in the health services area and provide needed information about the areas in which further assistance may be needed.

With this goal in mind, the specific objectives of the study are to:

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

These study objectives will be accomplished through the four data collection components shown in Exhibit A.2.1. These components are:

- Head Start Director Survey. Based on contact information available in the Head Start Program Information Reports, the universe of directors for Head Start grantees and delegates (including American Indian Alaska Native and Migrant and Seasonal Head Start grantees) will be invited to complete a short online survey to obtain basic information about the Head Start program and the activities in the health services area. The director will also be asked to provide the name and contact information for the health manager in their program. This survey instrument is attached in Appendix B.
- Head Start Health Manager Survey. Based on the contact information provided by the director, the universe of health managers for Head Start grantees and delegates will be invited to complete an online survey. This survey questionnaire, described more fully below, is attached in Appendix C.
- Head Start Health Manager Interviews. In order to obtain more in-depth information not possible with a structured survey question, a purposive sample of 40 health managers that completed the online survey will be invited to participate in a semi-structured telephone interview to probe more deeply into the topics covered by the online survey. The respondents will be selected to ensure that the sampled respondents capture variation along key Head Start program features such as different program types (Early Head Start, Head Start, American Indian and Alaska Native programs, and Migrant and Seasonal programs); program settings (urban versus rural); program options (center- versus home-based), staffing structure for the health services area, and so on (see Section B.1.2 for more detail). This interview protocol is attached in Appendix D.
- Head Start Teacher, Family Service Worker, and Home Visitor Interviews. In recognition of the important role played by other Head Start staff in the delivery of the health services area, a purposive sample of 60 teachers, family service workers, and home visitors, nominated by the health managers who complete the semi-structured phone interview, will be invited to participate in a semi-structured telephone interview to learn more about their role in the provision of the health services area. The approach to selecting the sample for this component

of the study will be similar to that used for the semi-structured health manager interviews (see Section B.1.2). This interview protocol is attached in Appendix E.

Exhibit A.2.1 Data Collection Components

Component	Study Population	Mode
Head Start Director Survey	Head Start directors for the universe of grantees and delegates	Online survey
Head Start Health Manager Survey	Head Start health managers for the universe of grantees and delegates	Online survey
Head Start Health Manager Interviews	Sample of 40 health managers that completed the survey	Semi-structured telephone interview
Head Start Teacher, Family Service Worker, and Home Visitor Interviews	Sample of 60 teachers, family service workers, and home visitors in programs where the health manager completed the interview	Semi-structured telephone interview

The structure and content of the survey instruments is guided by the study objectives and the conceptual framework shown in Exhibit A.1.1. For example, Module 1 of the Health Manager Survey (Appendix C) is focused on health managers, the Health Services Advisory Committee (HSAC), the staffing model and management structure of the health component, and professional development. Module 7 contains additional questions about the health manager's background. Turning to the health components in the framework, Module 2 is focused on understanding the range and prevalence of health conditions among the Head Start population, the effort undertaken by Head Start staff in regular management of those conditions, and communication strategies with parents/guardians about specific health concerns of their child. Module 3 is designed to describe the screening and referral processes of Head Start programs including linkages with health providers in the community and availability of regular sources of care. Module 4 is focused on Head Start activities in the areas of health promotion and prevention, including topic selection and prioritization, implementation challenges, other family health promotion activities, and the influence of state or local policies on such activities. Module 5 describes the Head Start activities to support staff wellness. Module 6 is designed to capture the network of health-related community partners (beyond medical/oral health providers) that support health activities in Head Start, as well as community engagement strategies undertaken by the program. Finally, the broader administrative context (e.g., follow-up, funding, monitoring) is assessed in Modules 2-5, where applicable. Some of these questions are also included in the Head Start Director Survey.

A matrix showing the linkages between the study objectives listed above and the questions on the four data collection components shown in Exhibit A.2.1 is provided in Appendix F.

The study aims to be inclusive by incorporating American Indian and Alaska Native and Migrant and Seasonal programs. While the study is undergoing OMB clearance, the RAND study team will be seeking clearance from relevant Institutional Review Boards for American Indian and Alaska Native groups.

A.3. Use of Improved Information Technology and Burden Reduction

The two survey-based data collection components for this study (the online surveys of directors and health managers shown in Exhibit A.2.1) will use RAND's Multimode Interviewing Capability (MMIC™), a computer-assisted data collection program, to reduce the burden on respondents. MMIC™ is used to help manage the data collection process including questionnaire layout (including skip patterns), sample management, fieldwork monitoring, and final dataset production. The system allows a user to begin the survey, save responses, and go back later to complete the remaining items. MMIC™ also offers a "Help Desk," which provides technical assistance for respondents through a toll free number and an actively monitored email account. Several illustrative screen shots from the Health Manager Survey are shown in Appendix G. The visual display of questions and response options will be similar for the Head Start Director Survey.

Through MMIC™, respondents can participate in the survey via the Internet, personal digital assistants (PDAs), smart phones, and WebTVs. MMIC™ can also support phone administration in the instances when a respondent does not have access to the Internet. An additional benefit of this approach is that respondents will have an option at the end of the survey to download and print their complete set of responses, which may be useful for strategic planning and goal setting.

The two other components of this study that involve semi-structured interviews are not conducive to computerized interviewing.

A.4. Efforts to Identify Duplication and Use of Similar Information

The Head Start Health Managers Descriptive Study is designed to complement, not duplicate, existing information and to provide information that does not currently exist. For example, the survey does not collect information that can be obtained from the Head Start Program Information Report that is collected annually by the Office of Head Start from each Head Start grantee. Instead, the basic information about program size and demographics from the Program Information Report will be matched with the survey data to provide a more complete database. The present study will also provide much needed current information about the Head Start health services area and the health manager workforce that does not exist elsewhere. Among prior studies, only the Descriptive Study of Head Start Health Services[5] provided a focused examination of the Head Start health services area and the role of the health manager, yet that information was collected in 1993-1995, nearly two decades ago and prior to the implementation of Early Head Start and without the inclusion of Migrant and Seasonal and American Indian and Alaska Native programs. Other studies like the Early Head Start Family and Child Experiences Survey (Baby FACES)[6] (2007-2012) or the Head Start Family and Child Experiences Survey (FACES)[7] (1997-2013) do not have an emphasis on the health services area. Several other studies have focused on narrow aspects of the health services area such as the

[5] Department of Health and Human Services. *Descriptive Study of Head Start Health Services 1993-1996* Undated. http://www.acf.hhs.gov/programs/opre/hs/descriptive_stdy/index.html

[6] Department of Health and Human Services. *Early Head Start Family and Child Experiences Study (Baby FACES) 2007-2012*. 2012.http://www.acf.hhs.gov/programs/opre/ehs/descriptive_study/index.html

[7] Department of Health and Human Services. *Head Start Family and Child Experiences Survey (FACES) 1997-2013*. 2012. http://www.acf.hhs.gov/programs/opre/hs/faces/index.html

Head Start Oral Health Initiative Implementation Evaluation[8] (2006-2008), the "*I Am Moving, I Am Learning*" Implementation Evaluation[9] (2006-2008), and the National Survey of Obesity Prevention Practices in Head Start.[10]

Where possible, questionnaire wording and response codes have been adopted from these and other prior surveys in order to enhance comparability across data sources and over time. However, in some cases, question wording and response codes were modified to be more relevant for the current study objectives. Such changes were informed by nine cognitive interviews with health managers serving a diverse mix of program types and input from the Technical Work Group. Appendix H shows the relevant survey sources for each survey question in the Health Manager Questionnaire found in Appendix C.

In addition, the survey and the resulting data will help identify questions that are critical to understanding the Head Start health services area and that would be useful for the development of sampling frames for future studies and for the collection of Head Start administrative data. Notably, the Office of Head Start currently requires that its Head Start and Early Head Start programs submit an annual Program Information Report (PIR), and provide periodic updates on such things as enrollment, center locations, and key staff. The annual PIR asks for information on services provided to children and families, and demographics of programs, children and staff including but not limited to program options, staff qualifications, home languages of children, and health and dental services. The PIR changes periodically to accommodate the changing information needs of the Office of Head Start and Congress. When there are changes, programs are informed in late summer so they can begin planning and collecting data well in advance of the submission deadline, which is usually at the end of August. Thus, the Head Start Health Managers Descriptive Study will be used to determine if any data currently collected in the PIR can serve as a good proxy in the future for the type of information needed to develop a sampling frame specific to the health services area. The Office of Planning, Research, and Evaluation will work with the Office of Head Start to share study findings and note potential implications for future standardized data collection, such as the PIR, to streamline collections, and to reduce the burden on programs.

In sum, this survey will provide the government with comprehensive up-to-date information that is not available from any other source. The resulting data will help to inform technical assistance to promote the health of Head Start families and children, inform decisions about capacity building and programmatic improvement, and identify information gaps to be addressed in future data collection efforts.

A.5. Impact on Small Businesses or Other Small Entities

No small businesses or small entities are expected to be impacted by the data collection in this study.

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[8] Department of Health and Human Services. *Evaluation of the Head Start Oral Health Initiative 2006-2008*. Undated. http://www.acf.hhs.gov/programs/opre/hs/eval_oral_health/index.html

[9] Department of Health and Human Services. *I am Moving I am Learning Head Start Implementation Evaluation Project*. 2012.http://www.acf.hhs.gov/programs/opre/hs/eval_move_learn/index.html

[10] Whitaker, et al. (2009.) A national survey of obesity prevention practices in Head Start. *Archives of Pediatrics & Adolescent Medicine* 163(12): 1144-1150. http://www.rwjf.org/healthpolicy/product.jsp?id=52688

A.6. Consequences of Collecting Information Less Frequently

This is a one-time collection.

A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances for the proposed data collection.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

In accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13) and Office of Management and Budget (OMB) regulations at 5 CFR Park 1320 (60 FR 44978, August 29, 1995), ACF published a notice in the Federal Register announcing the agency's intention to request an OMB review of this information collection activity. This notice was published on January 11, 2012, Volume 77, Number 7, page 1694, and provided a 60-day period for public comment. A copy of this notice is attached in Appendix I.

During the notice and comment period, the government received one request for a copy of the instruments; this request was fulfilled. The government also received two public comments which are attached with responses in Appendix J.

The Head Start Health Managers Study Technical Work Group members have been contacted for advice on various aspects of the design of the study and data collection instruments. Their feedback was obtained through an in-person meeting, telephone conversations, and emails. Members of the Head Start Health Managers Study Technical Work Group are listed in Exhibit A.8.1.

In addition, nine health managers were consulted through cognitive interviews to obtain their input on the clarity of the health manager online survey instrument and to get their feedback on any potential issues associated with completing the survey. In addition, one health manager and two family service workers reviewed the semi-structured interview protocols with the same objective. The draft survey instruments and interview protocols were revised to reflect this feedback.

Exhibit A.8.1 Membership of Health Managers Study Technical Working Group

Name	Affiliation
Sandra Barrueco	Catholic University of America
Harry Goodman	Head Start Regional Oral Health Consultant
Samuel "Woody" Kessel	University of Maryland
Jenifer Lindley Lipman	LACOE, HHSP
Linda McCauley	Emory University
Tammy Mann	The Campagna Center
Deborah Perry	Georgetown University
Michelle Sarche	University of Colorado – Anschutz
Robert Whitaker	Temple University

A.9. Explanation of Any Payment or Gift to Respondents

No payments or gifts will be offered to respondents participating in this data collection.

A.10. Assurance of Privacy Provided to Respondents

All persons who participate in this data collection, either through the web survey or the semi-structured interviews, will be assured that the personally identifiable information they provide will be kept private to the fullest extent allowed by law. Informed consent from participants will be obtained to ensure that they understand the nature of the research being conducted and their rights as survey respondents. Respondents who have questions about the consent statement or other aspects of the study will be instructed to call the RAND principal investigators or the administrator of RAND's Institutional Review Board.

In the case of Head Start directors and health managers who participate in the online survey, the consent script will appear on an introductory screen and the survey will only continue after the respondent has given their consent to participate. For those participating in the semi-structured interviews (e.g., health managers, teachers, family service workers, and home visitors), the consent script will be read as part of the introduction to the survey and the interviewer will not proceed unless oral consent is given. These consent scripts are included as part of the survey instruments and semi-structured interview protocols provided in Appendixes B, C, D, and E.

The study will have a Data Safeguarding Plan to further ensure the privacy of the information that is collected. For the online survey and semi-structured interviews, RAND will assign a data ID to each respondent. Neither names of respondents nor any other kinds of identifiers will appear in the survey or interview data. For the semi-structured interviews, personal identifiers that could be used to link individuals with their responses will be removed from all interview recording instruments and stored under lock and key at the research team offices. All contact data (including personal identifiers) collected during the study and stored in the Multimode Interviewing Capability (MMIC™) system will be encrypted using a Rijndael 256 standard and stored on a secure server. Contact information data and survey data will never be combined into one dataset. RAND will store the raw survey data in a MMIC™ database format on a secure server in a directory that is not externally accessible over the web, via shares, or via FTP. It is possible that some survey participants will contact RAND for technical assistance. In this regard, RAND will have access to participant-provided email addresses and names. RAND staff will respond directly to participants when they request assistance with the MMIC™ survey but will destroy participant contact information obtained as part of this request as soon as the technical problem has been resolved.

The consent procedures and Data Safeguarding Plan have been reviewed and approved by RAND's Institutional Review Board. Interview and data management procedures that ensure the security of data and privacy of information will be a major part of training.

A.11. Justification for Sensitive Questions

There are no personally sensitive questions in this data collection.

A.12. Estimates of Annualized Burden Hours and Costs

This proposed data collection does not impose a financial burden on respondents. Respondents will not incur any expenses other than the time spent answering the web survey questions and the semi-structured interview questions. The estimated annual burden for study respondents is shown in Table A.12.1.

Survey respondents will be Head Start directors at the grantee and delegate level; Head Start health managers at the grantee and delegate level; and Head Start teachers, family service workers, and home visitors. To compute the total estimated annual cost, the total burden hours were multiplied by the average hourly wage for each participant according to wage data compiled by the Bureau of Labor Statistics. For Head Start Directors, we used data for 2011 on the median weekly salary for full-time employees with a degree higher than a bachelor's degree ($33.65 per hour assuming an average work week of 40 hours).[11] For Head Start Health Managers, we used the 2011 median weekly salary for full-time employees over the age of 25 with a bachelor's degree from the same source ($26.33 per hour assuming an average work week of 40 hours). For Head Start teachers, family service workers, and home visitors, we used the mean salary for childcare workers ($10.15 per hour) based on the May 2010 National Occupational Employment and Wage Estimates for the United State (the most recent year available).[12]

Exhibit A.12.1 summarizes the reporting burden on respondents to the various instruments submitted for OMB clearance. The annual number of respondents for the Director Survey is equal to the number of grantees and delegate agencies (n=2,870). However, during pre-tests with nine EHS/HS health managers, it was discovered that in some rare cases, programs may have more than one health manager, as is the case for some Migrant and Seasonal Head Start Programs serving multiple states. As a result, we have rounded the number of respondents for the Health Manager Survey up to 2900 to ensure that all potential health managers are included in these burden and cost estimates. Response times were estimated from pre-tests with nine potential respondents to the Health Manager Survey and three potential respondents to the semi-structured interviews (one health manager and two family service workers). Note that although we expect the survey to take 45 minutes to complete, we have allowed for an additional 30 minutes for the health manager to collect or verify information that they may not have readily available. The annual burden is estimated from the total number of completed surveys and interviews and the minutes taken per instrument. The burden estimate for the Head Start Health Manager Survey includes time to gather any needed information.

Exhibit A.12.1 Annual Burden and Cost Estimates

Instrument	Annual Number of Respondents	Number of Responses Per Respondent	Average Burden Hours Per Response	Total Burden Hours	Average Hourly Wage	Total Annual Cost
Head Start Director Survey	2,870	1	0.25	717.5	$33.65	$24,143.88
Head Start Health Manager	2,900	1	1.25	3,625	$26.33	$95,446.25

[11] Bureau of Labor Statistics. *Labor Force Statistics from the Current Population Survey 2011, Quartiles and Selected Deciles of Usual Weekly Earnings of Full-Time Wage and Salary Workers by Selected Characteristics*. http://www.bls.gov/webapps/legacy/cpswktab5.htm

[12] Bureau of Labor Statistics. *May 2010 National Occupational Employment and Wage Estimates, United States*. http://www.bls.gov/oes/current/oes_nat.htm#39-0000

Survey						
Head Start Health Manager Interviews	40	1	0.75	30	$26.33	$789.90
Head Start Teacher, Family Service Worker, and Home Visitor Interviews	60	1	0.75	45	$10.15	$456.75
Total Annual Estimate				**4,417.5**		**$120,856.78**

A.13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

Not applicable.

A.14. Annualized Cost to the Federal Government

The total cost for the two years of data collection and reporting is $447,841 or $223,921 per year. These costs include the sampling (for semi-structured interviews), data collection and data coding, and the data analysis and report preparation.

A.15. Explanation for Program Changes or Adjustments

This submission to OMB is a new request for approval.

A.16. Plans for Tabulation and Publication and Project Time Schedule

A.16.1. Analysis Plan

The analysis plan for the Head Start Health Managers Study will be tailored to address each of the study's research objectives. Specifically, the mainly descriptive analyses will aim to (1) depict key characteristics of Head Start health managers and the role they, other Head Start staff, and community partners play in the health services area; (2) portray the array of health programs and services offered to Head Start children, families, and staff and how those services are tailored to meet the needs of the diverse populations served by Head Start; (3) describe the approaches used to prioritize, implement, monitor, and sustain initiatives in the health services area and the features of the local community and policy environment that may promote or hinder success; and (4) characterize the resources available at the program and community levels available to support the health services area. In this section, the analysis plan for the information collected through the two online surveys: Head Start Director Survey and Head Start Health Manager Survey is described. Then the analysis plan for the information collected through the semi-structured interviews with Head Start health managers and with Head Start teachers, family service workers, and home visitors is discussed.

Analysis of Information from Online Surveys. The analysis of the information collected in the two online surveys will have two main components: (1) development of nonresponse weights and (2) descriptive analyses.

(1) Development of nonresponse weights. As discussed in Section B.3, a number of strategies to maximize response rates to both the Head Start Director Survey and Head Start Health Manager Survey will be used. However, some nonresponse is expected so appropriate statistical procedures to correct for any potential nonresponse bias will be used. With some characteristics of all Head Start programs known a priori through information available in the Program Information Reports, non-response weights will be designed based on those program characteristics that will allow for reweighting the sample of survey respondents to be similar to the population of Head Start programs that were invited to participate. Logistic regression models will be used to predict the propensity of Head Start program director or a Head Start health manager participating in the survey and the inverse of the propensity will be used as non-response weights. Extremely large weights will be trimmed to avoid outliers and influential observations. These obtained weights will be used throughout the analyses for inference.

(2) Descriptive analyses. In order to address the study questions outlined above, summary statistics of the different survey questions (means, percentages) and cross tabulations or two or more questions will be reported in aggregate and for subgroups. The known relevant subgroups of interest include:

- Head Start program model (i.e., center-based Early Head Start and Head Start and home-based Early Head Start and Head Start);
- Head Start regional program units (i.e., the 10 geographic regions plus Region 11–American Indian and Alaska Native Programs and Region 12– Migrant and Seasonal Programs);
- Urban versus rural location; and
- Demographics of the population of participating families and children (e.g., programs with relatively larger shares of homeless children, children in foster care, and children with disabilities).

However, there are subgroups that cannot be anticipated in advance of the data collection that are expected to emerge as part of the descriptive analysis. These are expected to include subgroups defined by the education and training background of the Head Start health manager, by the staffing model for the health services area, by the operational model for the Health Services Advisory Committee (HSAC), by the nature of the relationships with community-based partners, or by the approaches to planning for and implementation of the health services area.

T-test or chi-squared tests will be conducted to test for differences across subgroups. Multivariate regression models will also be estimated to examine the factors associated with key outcomes of interest. Those outcomes will include, for example, the presence of specific barriers that health managers face in obtaining health-related services for children and families in their program and the health manager's rating of the adequacy of the community partnerships available for their program.

Analysis of Information from Semi-Structured Interviews. Drawing on state-of-the-art practices for analyzing qualitative data,[13] including grounded theory,[14] [15] the analysis plan for the semi-structured interviews with Head Start health managers and with Head Start teachers, family service

[13] Bernard H. *Social research methods: Qualitative and quantitative approaches.* Thousand Oaks, CA: Sage; 2000.

[14] Strauss A, Corbin J. *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage; 1990.

workers, and home visitors will include: (1) identifying themes, (2) building and applying a codebook, (3) describing themes, and (4) identifying patterns.

(1) Identifying themes. To identify themes (the abstract constructs that researchers may identify before, during, and after data collection), a variety of techniques, including those from the analytic tradition of grounded theory, to read a sample of transcripts to look for examples that suggest processes, actions, assumptions, and consequences will be used. Metaphors, repetitions across informants, and shifts in content that may indicate relevant themes will be explored. Text management software (ATLAS/ti) will be used to review texts and mark instances where each theme occurs.

(2) Building and applying a codebook. To increase inter-coder reliability and the validity of the findings, a codebook will be developed using standard procedures. Qualitative codebooks, similar to quantitative codebooks, list each theme (rather than each variable) accompanied by a detailed description, inclusion and exclusion criteria, and exemplars. Once the codebook is complete, we will meet to familiarize ourselves with a set of standardized procedures for marking chunks of text that pertain to each theme. To practice the procedures, we will select a random sample of transcript sections that we will each code independently. On completion, the coding will be reviewed as a group. Disagreement among coders will suggest where the codebook may be ambiguous and confusing. Ambiguities will be fixed and additional exemplars will be included in the codebook. The training will continue until coders are familiar with the codebook and can consistently identify and mark each theme when it appears in sample texts. Upon completion of the training, two coders will analyze each interview. The first coder will take the first pass at marking the text for themes. The second coder will re-examine the text to assure that no themes have been missed. In an exploratory analysis like this, we are more concerned with finding all examples of a theme and less concerned with calculating a measure of inter-coder agreement. Using two coders helps us accomplish this goal.

(3) Describing themes. Once coding is complete, we will use ATLAS/ti to retrieve all instances of each theme. We will review these instances and describe the theme by presenting segments of text—paraphrases of cases and verbatim quotes from informants—as typical and atypical examples of concepts. We will also examine the distribution of the theme across all groups.

(4) Identifying patterns. There are two types of patterns we will explore: (1) "cross group" themes that cut across all respondents and (2) "within-group" thematic similarities and differences that appear within respondent sub-groups. We will examine to what degree themes are central or peripheral to group members and how they might be distributed across various group characteristics. Finally, we will identify how themes from the qualitative interviews are linked to survey data. For example, we may sort the qualitative themes and map to categories in the quantitative data. Then, we will note the extent to which the interview data expand or align with a quantitative data point, or contradict a survey finding.

A.16.2. Time Schedule and Publications

Exhibit A.16.1 details the timeline for surveys with Head Start directors and Head Start health managers and Exhibit A.16.2 details the timeline for the semi-structured interviews.

Exhibit A.16.1 Timeline for Surveys with Head Start Directors and Head Start Health Managers

[15] Glaser B, Strauss A. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine; 1967.

Task	Planned Start Date	Planned End Date
Acquisition of survey frame and file preparation	OMB approval	220 days after OMB approval
Data collection activities	30 days after OMB approval	250 days after OMB approval
Data analysis	200 days after OMB approval	420 days after OMB approval
Prepare and submit report	300 days after OMB approval	450 days after OMB approval

Exhibit A.16.2 Timeline for Semi-structured Interviews with Head Start Health Managers, Teachers, and Family Service Workers

Task	Planned Start Date	Planned End Date
Sample selection	60 days after OMB approval	250 days after OMB approval
Data collection activities	80 days after OMB approval	280 days after OMB approval
Data analysis	230 days after OMB approval	420 days after OMB approval
Prepare and submit report	300 days after OMB approval	450 days after OMB approval

A final report and at least one research brief will be prepared and delivered five weeks before the project end date (November 2013). The report will have an executive summary that will present key findings as well as answers to the study research questions. The full report will describe the study purpose and research questions, detail the approach and data collection methodology, present the results of the analysis of both the survey data and the semi-structured interviews, and discuss implications of the findings for the Office of Head Start, Head Start grantees, and researchers who focus on the health of children in early childhood settings.

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

All instruments involved in this data collection will display the number and expiration date of OMB approval. The OMB number and expiration date will be displayed on the first Web page of the online Head Start Director Survey and the Head Start Health Manager Survey. The OMB number and expiration date will be read at the start of each semi-structured interview.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

No exceptions are necessary for this data collection.

List of Appendixes Under Separate Cover