Policy Brief: Early Head Start at 25

The Office of Head Start

Key Takeaways

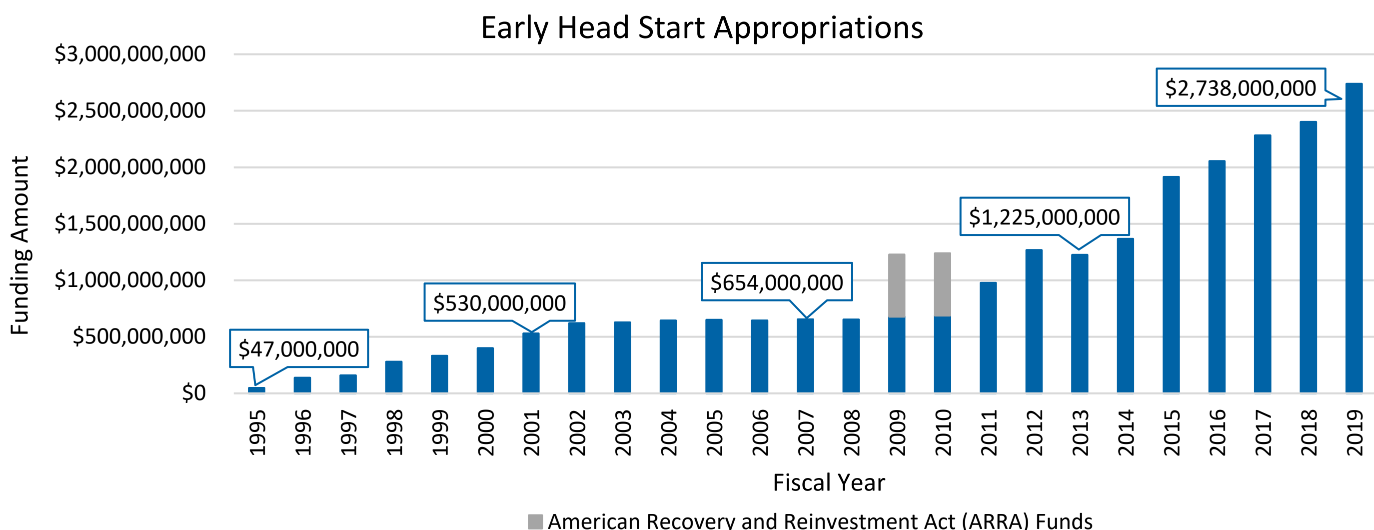
- The Early Head Start (EHS) program has provided family-centered, comprehensive services to over 3 million pregnant women, infants, and toddlers since the program's inception in 1995.
- Over the last decade, EHS funded enrollment has increased by over 60%. In 2019, EHS was funded to serve over 180,000 infants; however, less than 9% of income-eligible children under age 3 had access to these services.
- Researchers have studied the implementation and impact of EHS services on children and families since the program's authorization in 1994 to support continuous programmatic improvements. Studies have demonstrated that EHS has a statistically significant impact on a range of child outcome measures, such as cognitive, language, and social and emotional development.

Program Foundations

In September 1995, the Administration on Children, Youth and Families (ACYF) awarded the first EHS grants to provide comprehensive child development and family support services to low-income families with pregnant women, infants, or toddlers. Prior to this, Migrant Head Start programs enrolled the only infants and toddlers served by the Office of Head Start (OHS); these programs began providing services to farmworker families with children from birth to 5 in 1969. In 1994, the Secretary of Health and Human Services formed the Advisory Committee on Services for Families with Infants and Toddlers. It provided the framework and vision for the EHS program by outlining programmatic goals that focused on promoting the developmental growth of infants and toddlers; supporting parents as their children's primary teachers, nurturers, and educators; helping families achieve their personal goals; mobilizing communities to ensure families receive comprehensive services; and providing staff with developmental opportunities to ensure the delivery of high-quality services. The EHS program's commitment to excellence continues today, 25 years later.

Budget

The graph below illustrates EHS federal funding levels since the program's inception in fiscal year (FY) 1995. On average, the EHS appropriation has grown by approximately 23% each fiscal year.

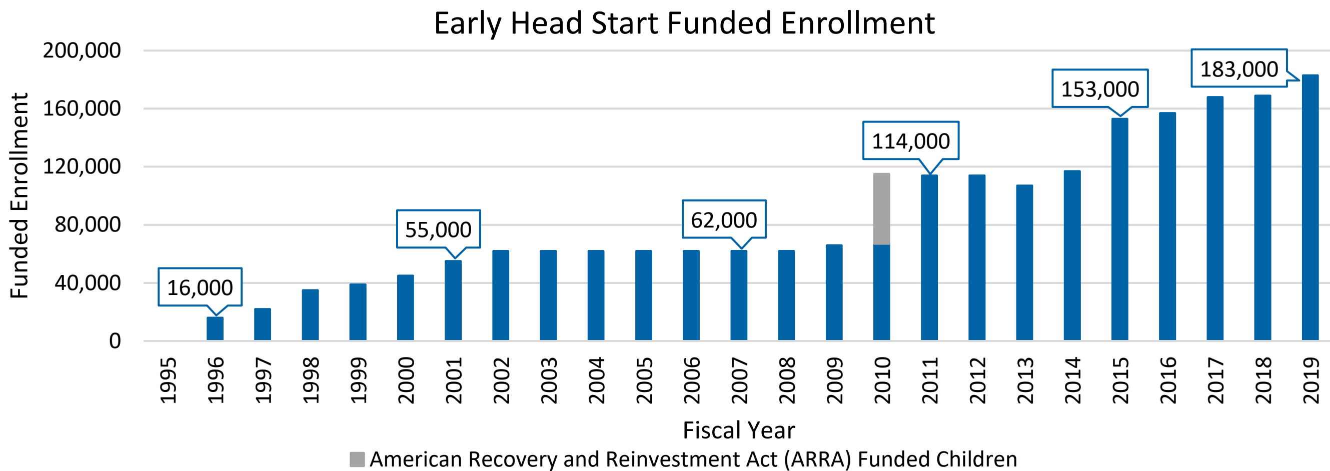


In 2009, the American Recovery and Reinvestment Act (ARRA) expanded Head Start funding and enrollment to support children, youth, and families. In total, ARRA directed $1.1 billion to EHS expansion for obligation in FY 2009 and FY 2010. This historic increase in funding allowed local programs to serve additional low-income children and families and assured

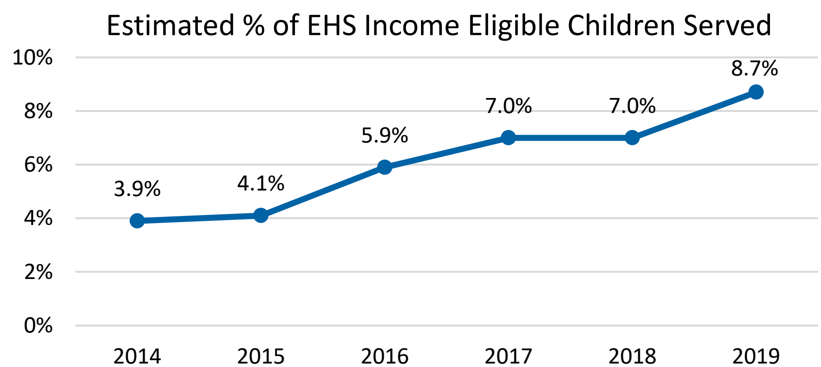
that Head Start grantees maintain high-quality programs. Although there appears to be a decrease in FY 2011 funding when compared to funding levels in FY 2010, funding across both FY 2011 and FY 2012 sustained support to maintain the expansions funded by ARRA. After ARRA, the EHS appropriation has continued to grow; funding for EHS has more than doubled since FY 2010, increasing by over 120%. These funding increases have supported programs in serving an additional 47,000 children through EHS Expansion and Early Head Start-Child Care Partnership grants and extending year-round care to over 10,000 EHS children in center-based and family child care settings.

Enrollment

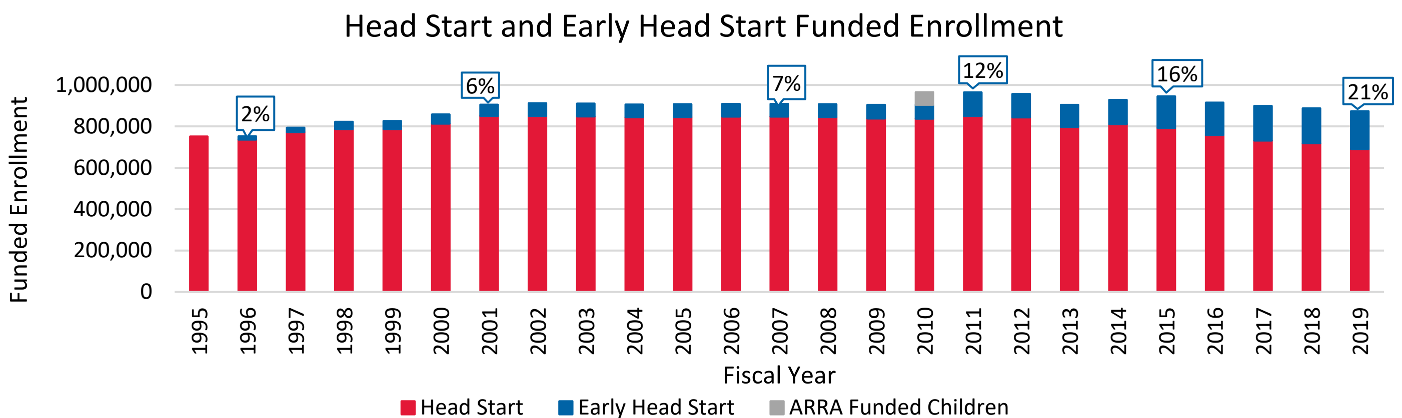
EHS funded enrollment figures have increased alongside its funding. A program's EHS funded enrollment represents the total number of EHS children and pregnant women that are supported by federal Head Start funds during the program year; these are referred to as enrollment slots. The reauthorization of the Head Start Act in 2007 provided the authority for Head Start grantees to shift funding from Head Start preschool slots to EHS slots, creating another mechanism for increasing EHS funded enrollment. The graph below illustrates EHS funded enrollment levels over the last 25 years.



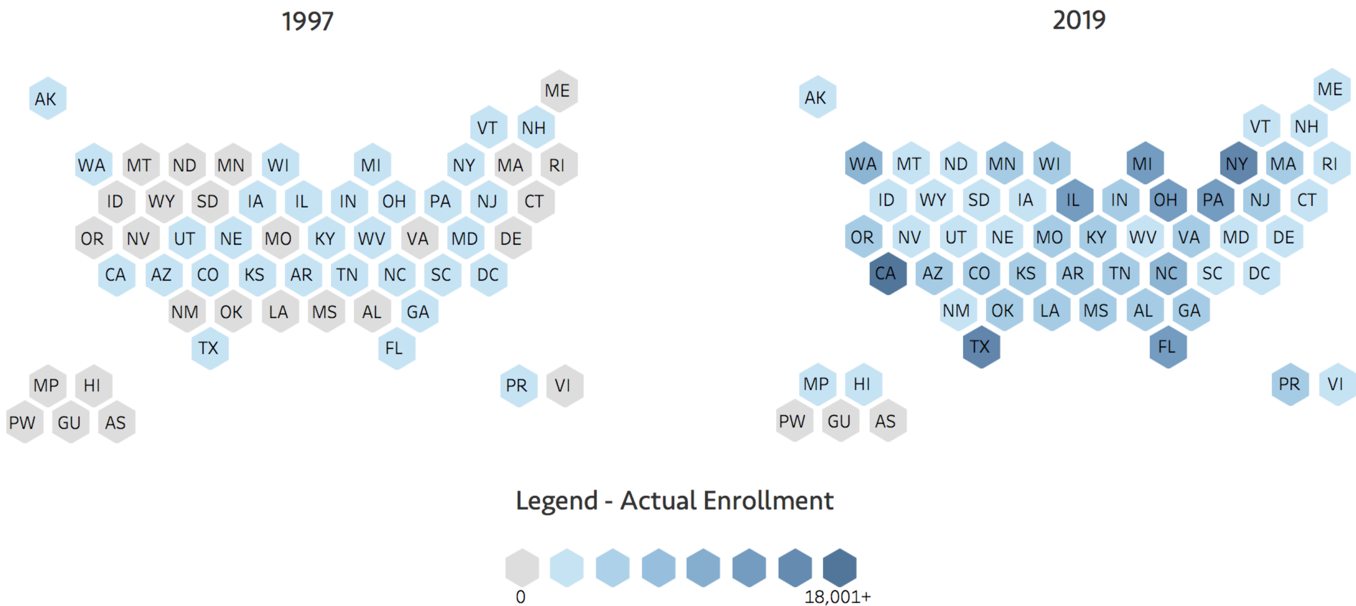
In 2019, approximately 9% of income-eligible children under age 3 had access to EHS services. This estimate was drawn using data from the U.S. Census Bureau Current Population Survey and American Community Survey. OHS considers families living below the federal poverty line income-eligible for EHS. This percentage is trending upward each year as the EHS program expands.



The majority of children served by OHS are preschoolers aged 3 to 5; however, infants and toddlers are becoming a larger proportion of children served each year. In 2019, EHS represented 21% of OHS's total funded enrollment.

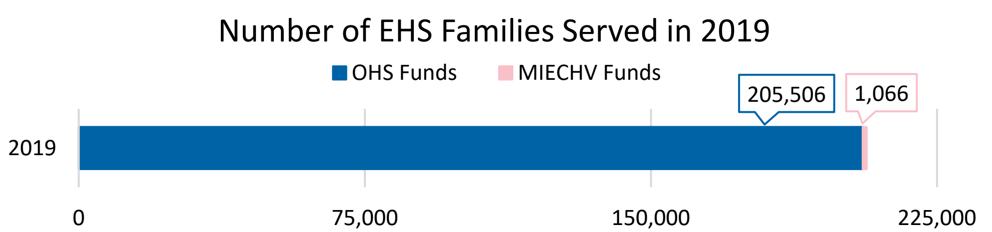


The first EHS programs were located throughout 29 U.S. states, the District of Columbia (DC), and one territory. Today, EHS programs operate in all 50 states, DC, and three territories. California currently has the largest number of EHS programs, providing services to over 35,000 infants, toddlers, and pregnant women in 2019.



The Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program

In 2010, the Patient Protection and Affordable Care Act established the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program. MIECHV is administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF). MIECHV facilitates collaboration at the federal, state, and local levels to improve outcomes for at-risk children and families through evidence-based home visiting programs. The EHS home-based option is one of the 19 evidence-based home visiting options states can implement. In total, 13 states have chosen EHS as one of their home visiting models.



In 2019, EHS programs served over 200,000 families throughout the program year. A portion of these families were served using funds from MIECHV. In total, 34 agencies received MIECHV funding to provide EHS home-based services to over 1,000 families. With these services, parents and children receive a minimum of 46 weekly home visits, lasting at least 90 minutes, and a minimum of 22 group socialization activities over the course of the program year.

Early Head Start Expansion and Early Head Start-Child Care Partnerships

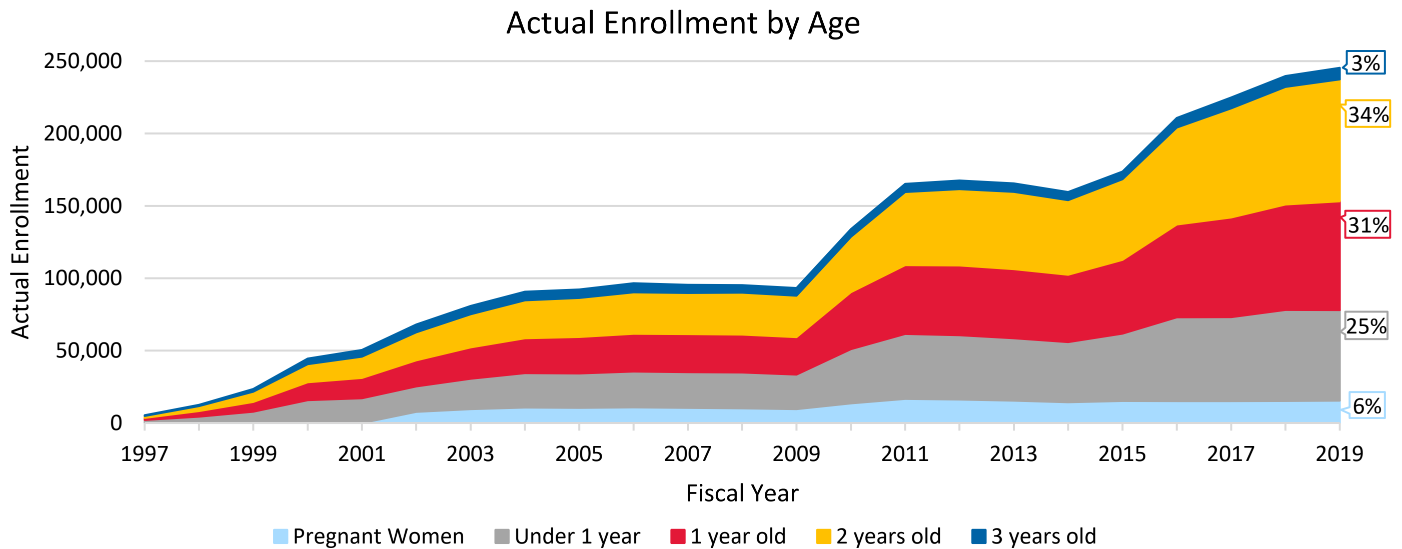
Since FY 2014, the Head Start appropriation has included funding for EHS Expansion and Early Head Start-Child Care (EHS-CC) Partnerships. This funding has allowed grantees to expand access to meet the needs for infant and toddler care in their community through traditional EHS programs or partnerships with center-based and family child care providers who agree to meet the Head Start Program Performance Standards (HSPPS) with funding and technical assistance from the EHS program. To date, ACF has awarded three rounds of funding in 2015, 2017, and 2019.

In the first round of funding, ACF awarded 275 EHS Expansion and EHS-CC Partnership grants to support services to approximately 32,000 children and families each year. In the second round of funding, ACF awarded 74 new grants to

provide high-quality EHS services for approximately 7,000 additional children. The third round of funding awarded 78 new grants, adding approximately 8,000 slots for infants and toddlers. Currently, these historic funding opportunities support services to approximately 12,000 children through EHS Expansion and 34,000 children through EHS-CC Partnerships. OHS will award a fourth round of EHS Expansion and EHS-CC Partnership grants in March 2021.

Children Served

The EHS program has enrolled approximately 3 million pregnant women, infants, and toddlers since it began in 1995. Actual enrollment is inclusive of enrollees who left during the program year and the enrollees who filled those empty slots. Prior to FY 2002, OHS counted pregnant women in the "under 1 year" category.



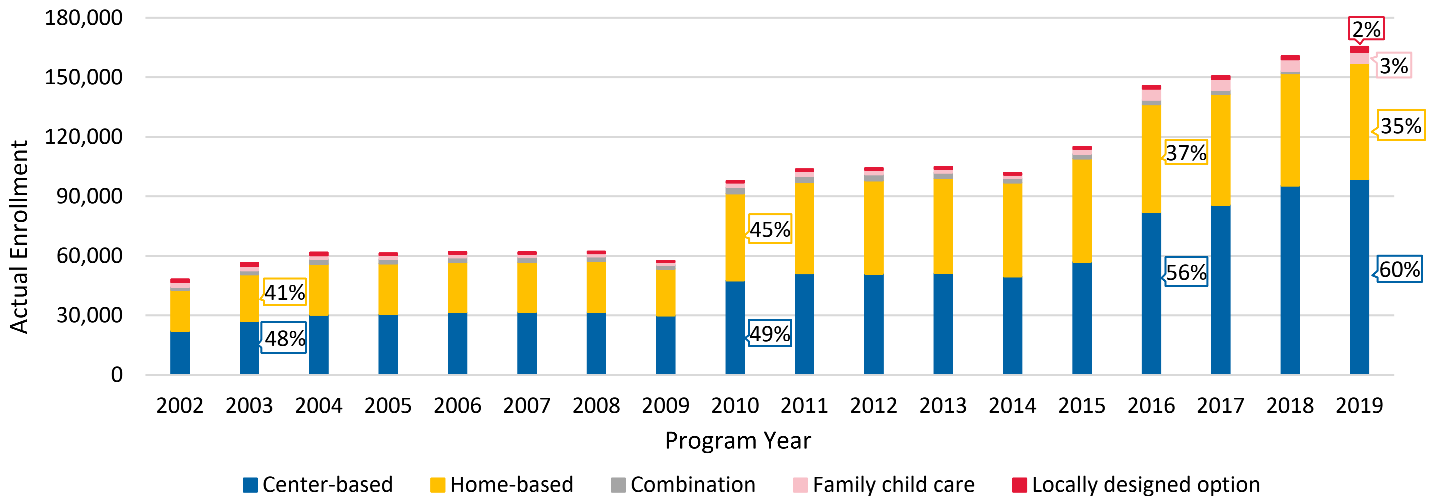
EHS programs establish a transition plan for each child at least six months prior to their third birthday to ensure appropriate placement and service following participation in EHS. Programs transition the child to a preschool slot as soon as possible after their third birthday. Therefore, nearly all 3-year-olds served by OHS are enrolled in Head Start.

Program Options

As infants and toddlers grow and change, and as family needs evolve, diverse program options can support them over time. When programs provide families with a choice of program options, families can stay within a consistent, supportive setting and receive developmentally appropriate care and services. Program options for EHS include:

- **Center-based:** Education and child development services are delivered primarily in classroom settings, located in an EHS center, school, or child care setting. Staff members also visit family homes at least twice per year. EHS centers generally provide year-round services (1,380 annual hours), and some provide extended program days to support working parents. To promote continuity of care for individual children, programs assign each teacher consistent, primary responsibility for no more than four children. The program minimizes teacher changes throughout a child's enrollment, whenever possible.
- **Home-based:** Weekly home visits provide the full range of EHS services to each enrolled child and family. The home visitor provides child-focused visits that promote the parents' ability to support their child's development. Additionally, programs offer at least 22 group socialization activities annually. These are designed to strengthen parent-child relationships and help promote parents' understanding of child development.
- **Combination:** Services are provided to children in both a center setting and through intensive work with the child's parents and family at home. Beginning in program year 2018-2019, OHS no longer considered this a standard program option for Head Start grantees. If a program offers a combination of program options to better meet the unique needs of families within their community, these slots are now captured in the locally designed program option.

- **Family child care (FCC):** Education and child development services are delivered to children primarily in a private home or family-like setting. Family child care providers operate sufficient hours to meet the child care needs of families and not less than 1,380 hours per year.
- **Locally designed program option variations (LDO):** Services are provided through an alternative program variation that has been approved by OHS and meets the service needs of families within the community.

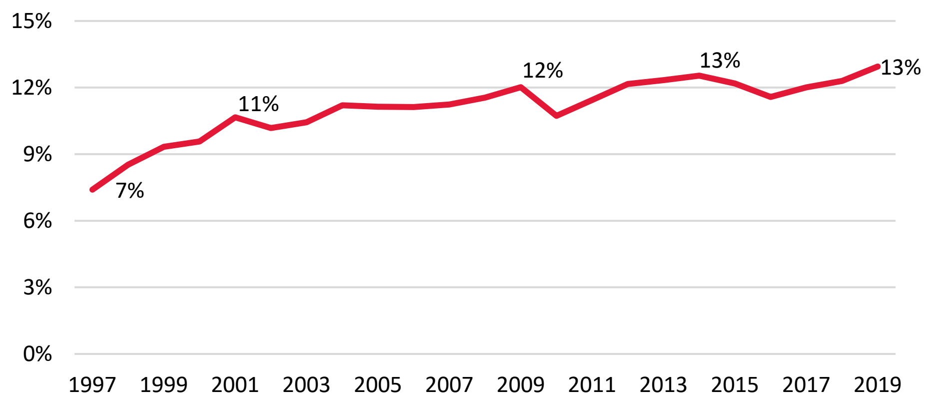


Historically, the majority of EHS enrollment slots have been concentrated in the center-based and home-based program options. Prior to 2002, funded enrollment in EHS home-based programs represented the largest proportion of children served. This shifted in 2002, when children enrolled in the center-based program option represented the largest share of funded enrollment in EHS — a trend that continues today.

Since 2015, the center-based and family child care program options have experienced the greatest rate of growth relative to the other EHS program options. Over the last five years, funded EHS enrollment has increased by 73% in center-based programs and 151% in family child care programs, compared to a 12% increase in home-based programs. This aligns with increased funding opportunities to provide full-day, full-year services in center-based and family child care settings. Center-based services are also more costly than home-based services, explaining the gap in the rate of increase between funding and funded enrollment.

Services for Children with Disabilities

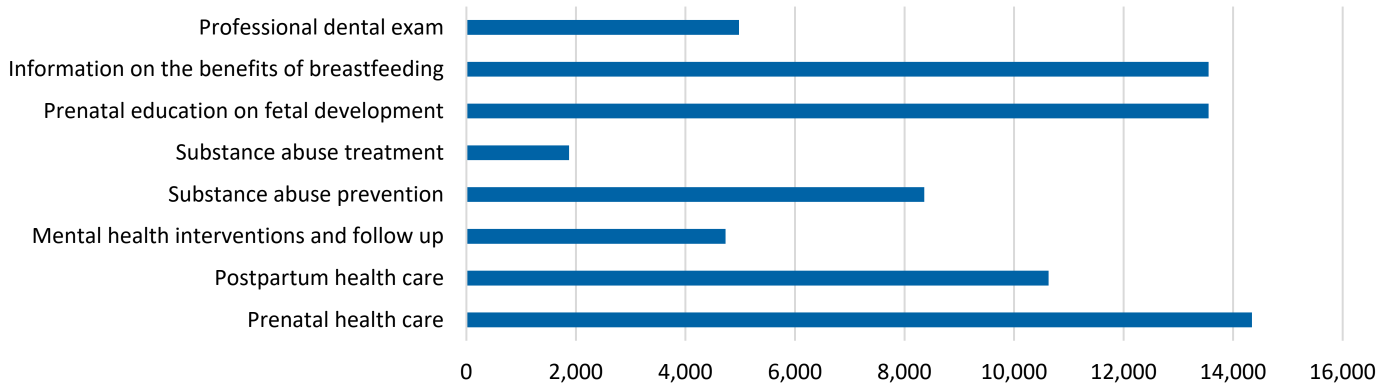
The Individuals with Disabilities Education ACT (IDEA) ensures a free appropriate public education is available for eligible children with disabilities throughout the nation. Part C of IDEA provides early intervention services to children from birth to age 3 with special needs.



Head Start grantees must ensure at least 10% of their total funded enrollment is filled by children eligible for services under IDEA, unless OHS grants a waiver. In EHS, Part C services include an Individualized Family Service Plan (IFSP) to outline the early intervention services a child and family will receive.

Services for Pregnant Women

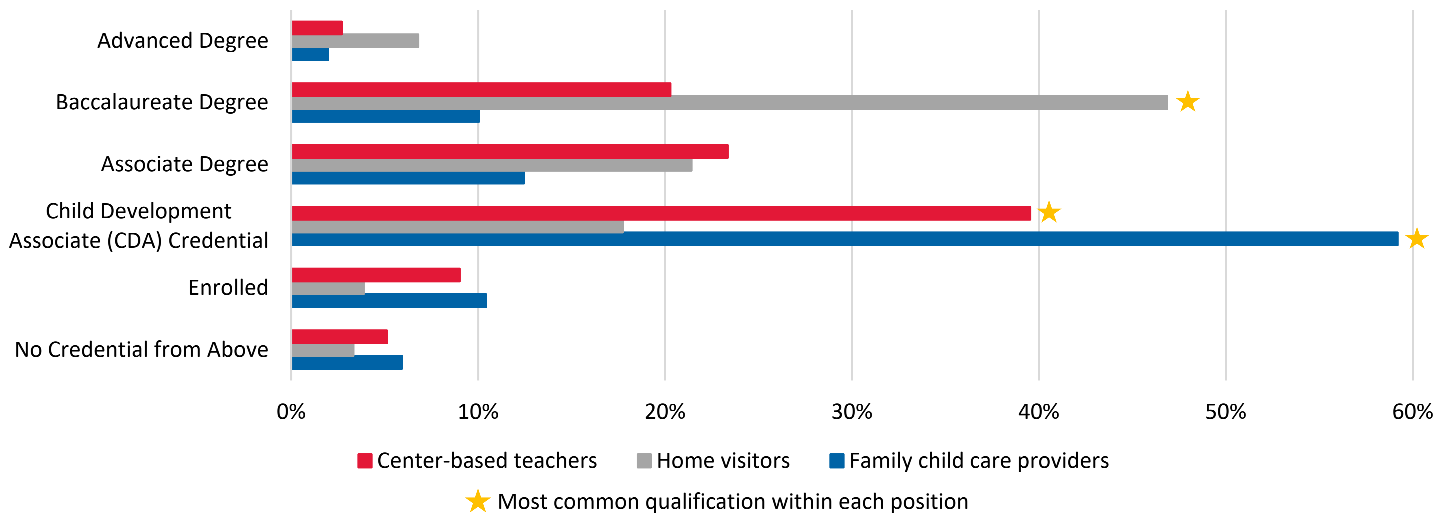
Programs funded to serve pregnant women enroll expectant mothers into the EHS program, but not within a specific program option. Services to enrolled pregnant women and their families can be delivered by the program or through referrals. After the baby is born and ready to begin education and child development services, the EHS program enrolls the baby into a specific program option that best meets the family's needs to ensure continuity of services. In 2019, OHS served over 15,000 pregnant women, who received a variety of comprehensive services.



Staff Qualifications

Programs must ensure all staff engaged in the delivery of program services have sufficient knowledge, training and experience, and competencies to fulfill the roles and responsibilities of their positions and to ensure high-quality service delivery. Programs provide ongoing training and professional development to support staff in fulfilling these responsibilities. EHS positions require, at a minimum, the following educational qualifications:

- **Center-based teacher:** A Child Development Associate (CDA) credential or comparable credential, or have equivalent coursework in early childhood development with a focus on infant and toddler development.
- **Home visitors**: A home-based CDA credential or comparable credential, or equivalent coursework as part of an associate's or bachelor's degree.
- **FCC provider:** Enrolled in a FCC CDA program or state equivalent and acquire credentialing within 18 months of beginning to provide services, or an associate's or baccalaureate degree program in child development or early education prior to beginning service provisions.



In 2019, over 46% of EHS center-based teachers held a degree higher than the minimum CDA credentialing requirement. Similarly, over 75% of home visitors and 25% of FCC providers exceeded their minimum educational requirements.

Research Findings

Since the authorization of EHS in 1994, ACF has funded numerous studies to examine the program's implementation and impacts on children and families. The two studies outlined below were conducted by the Office of Planning, Research and Evaluation (OPRE) and contracted by Mathematica Policy Research. There was a particular focus on partnerships between the research community, local programs, and OHS. The results of these studies identify and build on program strengths, refine and improve practices, and promote healthy growth and development of low-income children.

EHS Research and Evaluation Project (EHSREP), 1996-2010

The Early Head Start Research and Evaluation Project (EHSREP) was a large-scale, random-assignment evaluation of EHS. This project included an implementation study and an impact study. The study followed 3,001 children from enrollment to age 3 in 17 programs that were funded in 1995 and 1996. For the implementation study, programs were rated on 24 key indicators related to implementing the HSPPS, as well as other indicators of program start-up and operations. For the impact study, half of the sampled children participated in EHS and the other half did not but could receive other community services. Data were collected on family service use and a wide range of parent, family, and child outcomes when children were 14, 24, and 36 months old.[i]

The impact study found that EHS was broadly effective across a wide variety of child and family outcomes, such as:

- **Higher immunization rates:** 99% of EHS vs. 98% of control children were immunized.
- **Fewer hospitalizations:** 0.4% of EHS vs. 1.6% of control children were hospitalized for accident or injury.
- **Cognitive development:** EHS children scored higher on average than the control group using a standardized assessment; EHS children were less likely to score in the "at risk" range.
- **Language development:** EHS children had larger receptive vocabularies than control children.
- **Social and emotional development:** EHS children displayed lower levels of aggressive behavior, higher sustained attention, greater engagement of parent, and less negativity.
- **Parenting:** EHS parents displayed greater warmth, less detachment, more parent-child play, more stimulating home environments, more support for language and learning, more daily book reading, and less spanking.
- **Parent self-sufficiency:** EHS parents spent more hours in education and job training and were more likely to be employed.

Select findings from the implementation study[ii] included:

- Mixed-approach[1] programs demonstrated a pattern of strong and pervasive impacts, including on children's language and social and emotional development, parenting, and family self-sufficiency outcomes.
- Programs that fully implemented the HSPPS had the broadest pattern of impacts compared to programs that did not fully implement the HSPPS.

Two follow-up data collection phases were conducted in (1) pre-kindergarten[iii], when children were about 5 years old, to understand the effects of receiving EHS services on children's school readiness, and (2) fifth grade[iv], when children were about 10 years old, to understand if EHS had long-term impacts on child and family outcomes. Select results concluded:

- Prior to entering kindergarten, positive impacts of EHS remained in two areas of children's social and emotional outcomes, as well as several areas of parenting and parent well-being. Broader impacts were found for children and families who participated in programs providing home-based services.
- By grade five, EHS continued to have patterns of impacts for some sub-groups, but no longer had broad impacts for the overall sample.

EHS Family and Child Experiences Study (Baby FACES), 2007-2020

The Early Head Start Family and Child Experiences Study (Baby FACES) continues a series of ongoing descriptive studies aimed at maintaining an up-to-date, extensive knowledge base to support EHS policies and programs.[v] The 2009-2012

[1] "Mixed approach" refers to programs that offer both center- and home-based services, although individual families do not necessarily receive both.

round was a longitudinal study of 89 EHS programs and approximately 1,000 children in two age cohorts – a perinatal group of pregnant mothers or newborn children under 3 months old in 2009 and a group of infants about 1 year old in 2009. Data were collected annually until children aged out of the program at 3. Selected findings are as follows:

- 71% of programs offered more than one service option to families, illustrating that EHS programs individualize services based on family needs.
- Almost all children and families received services in their home language. 95% of families enrolled in home-based services and 96% of children enrolled in center-based services received care in their home language.
- At age 2, 97% of children had health insurance and 99% had a regular health care provider.
- Most EHS families provided a home environment that was emotionally supportive and cognitively stimulating.
- 73% of children were in classrooms scoring in the high range or above a 5 in Emotional and Behavioral Support. Classrooms were scored using the Classroom Assessment Scoring System: Toddler Version and rated on a scale of 1 (inadequate) to 7 (excellent).

Baby FACES has informed program planning and technical assistance at the national level for over a decade. A second round of Baby FACES was conducted in 2018 using a cross-sectional design, building upon the 2009 study's framework and findings. OHS expects findings from this second round in late 2020; a third round will launch in 2021.

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[i] U.S. Department of Health and Human Services (2006). *Early Head Start Benefits Children and Families*. Retrieved from the Administration for Children and Families: https://www.acf.hhs.gov/sites/default/files/opre/research_brief_overall.pdf

[ii] U.S. Department of Health and Human Services (2009). *How the Performance Standards Support New Early Head Start Programs: Lessons Learned from Research.* Retrieved from the Administration for Children and Families: https://www.acf.hhs.gov/sites/default/files/opre/implementr2pbrief.pdf

[iii] U.S. Department of Health and Human Services (2006). *Preliminary Findings from the Early Head Start Prekindergarten Follow-up*. Retrieved from the Administration for Children and Families: https://www.acf.hhs.gov/sites/default/files/opre/prekindergarten_followup.pdf

[iv] Vogel, Cheri A., Yange Xue, Emily M. Moiduddin, Ellen Eliason Kisker, and Barbara Lepidus Carlson (2010). *Early Head Start Children in Grade 5: Long-Term Follow-Up of the Early Head Start Research and Evaluation Study Sample*. OPRE Report # 2011-8, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from the Administration for Children and Families: https://www.acf.hhs.gov/sites/default/files/opre/grade5.pdf

[v] U.S. Department of Health and Human Services (2015). *The Faces of Early Head Start: A National Picture of Early Head Start Programs and the Children and Families They Serve.* OPRE Report #2015-29, Washington, DC. Office of Planning, Research, and Evaluation. Retrieved from the Administration for Children and Families: https://www.acf.hhs.gov/sites/default/files/opre/babyfaces_bro_v18_508_compliant_v2_opt.pdf