Enhancing Partnerships for Head Start and Oral Health

Special Population Forums: Final Synthesis Report

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Report Overview

In September 2001, the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA) and the Head Start Bureau (HSB) in the Administration for Children and Families (ACF) initiated the Head Start Oral Health Partnership Project. Under this 4-year project, a series of regional, special population, and professional organization forums were conducted to explore issues and strategies for improving the oral health of children and families served by Head Start and Early Head Start.

The two Special Population Forums were conducted in Head Start Regions XI, the American Indian-Alaska Native (AI-AN) Program Branch, and Region XII, known as the Migrant and Seasonal Program Branch, in June 2005 and February 2003, respectively. Although the AI-AN and Migrant and Seasonal Farmworker populations each have unique needs, the forums identified many common issues and challenges related to prevention, oral health education, and access to oral health care. Those identified as being of priority concern to both populations include:

- Lack of understanding regarding the importance of oral health
- Unclear and inconsistent oral health messages
- Lack of oral health data collection
- Oral health workforce challenges
- Funding or reimbursement challenges
- Barriers inherent in geography or a migrating population

This report discusses these issues and provides a range of strategies suggested by forum participants for addressing them. The report also discusses several cross-cutting recommendations that represent views emerging across the two Special Population Forums:

- Support the development of unified consistent oral health messages for use by Head Start programs

- Support data collection, applied research, and demonstration programs on the extent of oral health challenges and interventions to improve oral health in Region XI and XII Head Start programs

- Identify ways to recruit and support dental professionals to serve pregnant women and children enrolled in Region XI and XII Head Start programs.

Importantly, these recommendations are also consistent with the findings that emerged from the other forums conducted under this project. For this reason, they may be considered as important priorities for future national action to improve the oral health of children and families served by Head Start and Early Head Start.

I. Introduction

A. The Head Start – MCHB Oral Health Partnership

In 1999, the Head Start Bureau (HSB), the Health Resources and Services Administration (HRSA), Centers for Medicare and Medicaid Services (CMS, then known as the Health Care Financing Administration), and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) convened a National Head Start Partners Oral Health Forum to focus attention on early childhood oral health. The purpose of the forum was to discuss strategies for improving oral health status among young children and for increasing collaboration at the Federal, State, and local levels to enhance access to oral health services. One outcome of this National Forum was the development of an Intra-Agency Agreement between the HSB, Administration for Children and Families (ACF) and Maternal and Child Health Bureau (MCHB), HRSA to develop linkages to support oral health in Health Start. As part of this agreement, the two Bureaus decided to sponsor a series of regional, special population, and professional organization forums to determine how organizations and agencies could work together to improve the oral health of children and families in Head Start and Early Head Start.

The forums were planned and conducted over the course of a four-year period beginning in September 2001 and concluding in September 2005. This Head Start Oral Health Partnership Project was executed by Health Systems Research, Inc. under contract with the MCHB. Jane Steffensen of the University of Texas Health Science Center at San Antonio served as an Expert Consultant on the project. John Rossetti, DDS, MPH, the former Chief Dental Officer at the MCHB and consultant to a number of MCHB oral health initiatives also served as a resource throughout the planning process. Reports on each of the 10 Regional Forums, 2 Special Population Forums, and the 3 Professional Organizations Forums can be found on the National Maternal and Child Oral Health Resource Center Web Site at www.mchoralhealth.org/HeadStart/hsforums.html.

This report synthesizes the key findings and recommendations that emerged from the 2 special population forums convened with American Indians–Alaska Natives (AI-AN) and migrant and seasonal farmworkers (MSFW), respectively. (Synthesis reports for the regional forums as well as for the special population forums are also available on the National Maternal and Child Oral Health Resource Center Web Site at the aforementioned Web address.) Due to the unique characteristics of these regions, background information is also provided on the regions, populations, and cultural considerations. The findings in this report, combined with those from the other forums held under this project, can provide a framework for a National Action Plan to improve the oral health of all pregnant women and children in Early Head Start and Head Start.

B. Overview of the Special Population Forums

The two special population forums were held in Regions XI, the American Indian-Alaska Native Program Branch, and Region XII, known as the Migrant and Seasonal Program Branch. The Migrant and Seasonal Head Start Oral Health Forum was conducted on February 6, 2003, in Washington, DC, in conjunction with the National Migrant and Seasonal Head Start Conference, and the AI-AN Head Start Oral Health Forum was held on June 12, 2005 in Green Bay, WI as a component of the National Indian Head Start Directors Association Conference.

The goals of the forum were to:

- Discuss critical oral health issues the impact the children in Head Start programs in Regions XI and XII
- Assess access to care and other issues that may improve or detract from oral health education and clinical services available to the populations in these regions
- Develop strategy plans for the special population communities that include assessment of current regional issues, priority gaps, promising practices, and problem areas
- Allow for dialogue about strategies to address the oral health needs of children in these regional Head Start programs

- Contribute to the development of a national strategic plan to improve the oral health of children in Head Start and Early Head Start.

Participants attending the Forums represented broad geographic areas from through the country. Among the participants were MCHB and Head Start staff, representatives of Head Start Training and Technical Assistance Networks and Collaboration Offices, Head Start health coordinators, family service specialists, and parents. Participants also included tribal representatives, WIC and Medicaid program representatives, State dental directors and oral health program staff, IHS staff, dental care providers, representatives from national associations, academic institutions with resource and policy centers, and foundations and nonprofit organizations working with children and families served by Regions XI and XII.

II. Background: Special Population Regions and Populations

Due to the unique needs of the AI-AN and MSFW populations, the MCHB and HSB determined that these Head Start forums should be considered separately from the other regional forums. This section provides background on the unique characteristics of these populations and the regional structures designed to serve their needs.

A. Overview of Region XI—American Indian and Alaska Natives—and Region XII—Migrant and Seasonal Farmworkers

The HSB established separate regions in order to provide services to AI-AN children and children of MSFWs enrolled in Head Start Programs. Regions XI and XII Head Start programs are designed to provide specialized services and meet the unique needs of the children and their families whose cultures and lifestyles may differ in significant ways from the families enrolled in HS/EHS programs in the 10 other HRSA regions.

Regions XI and XII function similarly to HRSA's other 10 Regions in that regionwide conferences and technical assistance resources are focused on their specific needs however, their coverage areas include the entire country rather than distinct States and the majority of their programs are located in rural rather than urban communities. In addition, both Regions

are administered from the HSB National Headquarters in Washington, DC. Due to the relative isolation of the geographic areas served by Head Start programs in both Regions, these programs often have limited access to resources in their communities.

Structurally, the AI-AN Head Start programs that comprise Region XI are different from other regional programs because they work directly with the governance structure of sovereign tribal nations. This relationship has unique benefits and difficulties since tribal elections occur every 1 to 5 years and can result in high staff turnover at the tribal level. Currently, there are 150 Head Start and 42 Early Head Start AI-AN programs in 27 States and in all Indian Health Service (IHS) areas. The funded enrollment is 23,792.

The MSFW population is a diverse one, and its composition varies across geographic areas of the country. However, it is estimated that 85 percent of all migrant workers are racial and ethnic minorities, of whom most are Hispanic (including Mexican-Americans as well as Mexicans, Puerto Ricans, Cubans, and workers from Central and South America). The migrant population also includes Blacks/African-Americans, Jamaicans, Haitians, Laotians, Thais, and other racial and ethnic minorities. Although some workers live apart from their families and travel, work, and live in groups of single men, often under the supervision and control of a crew leader, many others, especially in the Midwestern migrant stream, travel with their entire family. It is their children who attend the Migrant and Seasonal Head Start (MSHS) programs, which often operate from 8 to 14 hours a day, 5 to 7 days a week, to accommodate the needs of families engaged in agricultural work. There are two types of migrant and seasonal grantees: home-based programs serving families in areas they call “home” and upstream programs serving families as they follow the ripening of various crops. Upstream Head Start programs may be in session only during the harvests. According to the most recent information, there are 26 MSHS grantees and 38 delegate agencies operating approximately 449 centers in 36 States. These programs serve over 33,000 children of migrant and seasonal families, 45 percent whom are under the age of 3 and 87 percent for whom Spanish is a native language.

The children served in both Head Start Regions have important characteristics that influence their overall well-being as well as the health of their families and communities. AI-AN and migrant families encounter common challenges including:

- Economic and social barriers related to life in remote rural or frontier locations
- Family incomes below the Federal poverty level
- Limited access to comprehensive health care
- High infant mortality rates
- Poor nutrition (often due to limited access to fresh food or cooking facilities)
- Substandard living conditions often without access to fluoridated water
- Low educational and literacy levels of parents.

In addition, migrant children face dangerous levels of exposure to the pesticides used on farms and many tribes struggle with high rates of depression and alcoholism. Despite the geographic and ethnic diversity represented in these Regions, the oral health of both AI-AN and migrant children often fare worse than their peers in the general population. Due to various socioeconomic challenges, their families often access emergency oral health services rather than preventive care. Head Start programs in these Regions serve families with diverse traditions, heritages, and languages that are different from families served in urban Head Start programs. For example, both Regions include families living in extreme poverty who may speak English as a second language and have distinct cultural beliefs towards health and illness and often a well-founded distrust of mainstream services or programs.

Although the purpose of this special population synthesis report is to combine the recommendations that emerged from the AI-AN and the migrant and seasonal farmworker Regional Forum it should be noted that great diversity can be found among the children enrolled in AI-AN and MSHS programs. Participants at each forum noted some distinct characteristics for both populations and they are outlined in the table below.

Table 1. Regions XI and XII, Population Characteristics	
Region XI – American Indian & Alaska Native	**Region XII – Migrant & Seasonal**
Families are U.S. citizens	Parents may be immigrants or on work visas
Tribal life is structured and geographically stable	Migrant lifestyle includes frequent moves, that often impede a family's ability to keep appointments for dental services
Head Start programs are ongoing	Head Start programs of short duration
High unemployment rates	Employed in agriculture work for short periods of time and low wages
Health care may be accessible through IHS or tribally managed health care programs	Health care may be accessible through Migrant Health Centers
Pregnant women are eligible for services in Early Head Start	Pregnant women are not eligible for services in MSHS

B. Health Care Services for AI-AN and Migrant Populations

Since oral health is a component of overall health, an understanding of the federally funded programs whose intent is to meet the health care needs of these populations is important. Unlike the other 10 HRSA Regions, the structures and services provided by these Federal health programs provide the context for the oral health service delivery system for Regions XI and XII. The IHS, an agency within the Department of Health and Human Services, is responsible for providing health services to AI-ANs. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the Federal Government and Indian tribes that was established in 1787. The IHS is the principal Federal health care provider and health advocate for Indian people, and its goal is to "raise their health status to the highest possible level." Health services are administered through 12 IHS Area Offices in conjunction with IHS and tribally operated health care services. Health care is provided through a system of IHS and tribally contracted

hospitals, health centers, school health centers, health stations, and Alaska village clinics. The IHS currently provides health services to approximately 1.5 million AI-ANs who belong to more than 557 Federally recognized tribes in 35 States.

In addition, AI-ANs and MSFWs are served by Federally Qualified Health Centers (FQHCs) that have been approved by the government to provide low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, such as preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless. The health services provided at Migrant Health Centers include a broad array of culturally and linguistically competent health and support services for MSFWs and their families. However, due to funding limitations Migrant Health Centers are able to serve only 20 percent of MSFW population since funding amounts to less than 25 percent of costs.[1] Despite the intent of the IHS and FQHCs to meet the health and oral health needs of these populations, limited resources, including severe workforce challenges, make it impossible to meet the multiple health needs, including oral health, of these families.

C. Cultural Considerations

One purpose behind convening these special population forums was to gain insight into the needs of underserved populations that reflect the ever-changing demographics of the client and provider populations in this country. Due to the long-standing disparities in the health status of people with diverse racial, ethnic, and cultural backgrounds, MCHB and the HSB wanted to learn about strategies to improve the quality of oral health services and outcomes for AI-AN and MSFW populations served by Head Start programs. All action steps to address prevention, oral health education, and access to dental care will require an understanding of the health beliefs and practices of these specific populations, along with the disparities and barriers they face when accessing services. Successful strategies will necessitate careful consideration of the design, delivery, and promotion of culturally appropriate oral health services to these families. Development of these services requires openness to the expectations, perceptions, and realities

[1]Migrant Health Issues, October 2001

of various communities. Within this context, it is important to understand that culture influences oral health practices and outcomes for a variety of reasons, including:

- Perceptions of illness and disease and their causes varies among cultural groups
- Diverse belief systems exist in relation to health, healing, and wellness
- Culture influences communication styles, health-seeking behaviors, and attitudes towards providers
- Providers may lack awareness or hold biases toward specific cultural groups.

One example of cultural norms that influence interactions between AI-ANs/MSFWs and their health providers is communication styles. Within many AI-AN cultures, a longer pause between speakers is used than in speech patterns of White people, which typically involve people talking on top of another's words. This pause is to allow time for the initial speaker to add any other thoughts or ideas before the listener responds. Yet this pause can be misinterpreted by the provider as an indication that the client did not understand what was said during the interaction. Within MSFW communities, there is often a preference for positive social relations based on politeness and respect, as well as avoidance of confrontation and criticism. Because overt disagreement is not considered appropriate behavior, a client may not agree with the proposed care plan but be hesitant to raise questions. The provider may assume simply that there is no need to consider alternatives.

Cultural competence also is required when it appears that a parent is not adhering to preventive oral health activities. For example, a culturally competent provider would be sensitive to the fact that AI-AN populations may be using herbal or folk remedies to treat oral disease and thus may not identify a need for other interventions. Traditional approaches to avoid baby bottle tooth decay may be unrealistic for a migrant mother working 14 hours a day in the fields. Migrant workers often share communal living space with other families, making it critical for a mother to be able to soothe and quiet her infant, a task most easily accomplished by giving the child a bottle of sweetened milk or juice at the end of a long workday. Working closely with AI-AN and migrant populations in designing interventions, engaging dental professionals in

cultural competency training, and being mindful of the need to respect all cultures and traditions are key elements in developing action steps that will have an impact on the oral health status of these and other special populations. Thus, it is important to consider the cultural and social contexts of the families and communities served by Regions XI and XII when implementing future strategies to improve oral health education, enhance prevention, and increase access to dental care in Head Start programs.

III. Priority Issues and Strategies

Upon registering to attend either the Region XI or XII Head Start Oral Health Partnership Forum, attendees were asked to prioritize their interest in participating in breakout discussions concerning one of three topics: oral health education, prevention, or access to oral health care. Participant selections were reviewed and assignments made to ensure balanced discussion.

During the breakout sessions, attendees engaged in facilitated discussion to identify challenges and promising practices of relevance to their Head Start programs. After prioritizing these challenges, the groups then outlined potential action steps that could be undertaken on a regional level to improve oral health education, prevention, and access to oral health services. Skilled facilitators helped guide the discussion in the groups. Although the focus for all forums was primarily on regional-level interventions, suggestions also emerged regarding promising State and local strategies to improve the oral health of participants in Head Start. The issues/challenges and strategies identified as priorities by forum participants are summarized in the following discussion.

A. Oral Health Education and Prevention

Due to significant areas of overlap in the challenges and recommendations that emerged from the prevention and education groups, the themes and recommendations that emerged from these group discussions in the AI-AN and MSFW forums are combined for the purposes of this synthesis report.

1. Issues and Challenges in Oral Health Education and Prevention

Despite the inherent differences between AI-AN and MSFW populations mentioned earlier, a review of the reports detailing the discussion from the oral health education and prevention breakout sessions reveal some interesting similarities. These common challenges include **a lack of understanding of the importance of oral health; unclear and inconsistent oral health messages;** and **a lack of oral health data collection,** such as applied research and demonstration projects to track oral health needs and evaluate oral health strategies for AI-AN and MSFW communities.

Participants in both forums resonated with the concerns expressed during other Head Start Oral Health Partnership Forums in expressing that in many instances oral health is not valued by Head Start families in the same way as overall physical health. Both groups relied primarily on emergency oral health care rather than preventive care for their children. When asked to account for this "crisis care" approach to oral health, forum participants suggested a variety of factors. They suggested that low-income families facing multiple economic and social stressors only have the resources to address the family's most critical needs. The perception is often that, unless there is debilitating pain, there is no need to see a dentist. Representatives from the Regions suggested that a low level of parental education was one factor contributing to this lack of awareness and misperceptions. They also felt that literacy challenges in general, especially for non-English speakers, impaired the ability of families with children in Head Start to understand the relationship of oral health to physical health, school readiness, self confidence and the ability to consume nutritious foods.

Participants in the discussion groups also noted that although parents were more accustomed to taking their children to see primary care clinicians such as family physicians and pediatricians, in many cases these clinicians and dental professionals were not providing the same message regarding the age to begin and the frequency of dental visits. In addition, primary care clinicians often did not screen children's gums and teeth or give advice on how to prevent baby bottle tooth decay or other oral diseases. The lack of clarity from health professionals themselves added to the confusion of families as to the importance of preventive care. In

addition to the lack of uniform preventive oral health messages, the forum participants felt as though there was no clear mechanism through which to distribute oral health information to Head Start program staff, children, and their families and, most notably, to families in which English is spoken as a second language and parental literacy levels are low.

The discussion groups also noted that although oral health professionals and Head Start staff members are aware of the importance of prevention and oral health, AI-AN and Migrant families might remain skeptical about the extent of the problem and unaware of prevention practices. Participants in the small groups noted the need for better oral health data collection, applied research, and demonstration projects to track oral health needs and evaluate oral health strategies for both of these special populations. This research must then be translated into forms and formats that can influence and educate AI-AN and Migrant decision makers on the extent of oral health problems as well as the importance of implementing solutions for their children.

2. Strategies for Improving Oral Health Education and Prevention

Participants in the small-discussion groups were energized by the opportunity to brainstorm on strategies that could lead to solutions and eliminate the challenges they encountered in oral health education and prevention for AI-AN and Migrant families. The breakout session participants in both Regions XI and XII independently reached similar recommendations to address the priority challenges identified in the areas of oral health education and prevention.

Regarding the lack of understanding of the importance of oral health, they offered suggestions as to the types and forms of information needed and ways to educate and inform families. As for the lack of a consistent oral health message, they discussed the need to start with professional dental education institutions and then create culturally competent materials that could be used by Head Start program staff to educate children and their families. Finally, they had suggestions for action steps to create a research base on oral health needs as well as successful outreach strategies for special populations. Each of these will be discussed in turn.

Strategies to address lack of understanding of the importance of oral health:

- Head Start health coordinators, family service specialists, outreach staff, and teachers must be trained in oral health education and how to incorporate that into daily programming with recognition that both new and existing staff needs training.

- Once that is accomplished, there must be increased opportunities for Head Start program staff to educate parents on the importance of oral health. This could include family outreach activities or events such as breakfast, lunch, evening, or weekend sessions with child care, food, or other incentives to encourage participation.

- Programs should develop oral health questions for individual family needs assessments with a checklist of possible barriers to care. Once the need is established an oral health component should be added to family partnership agreements.

- Finally, both time and funding should be allocated to develop and implement innovative oral health education and prevention initiatives for AI-AN and Migrant families.

Strategies to address unclear and inconsistent oral health messages:

- Head Start should develop a single uniform toolkit with training guides on oral health for use throughout the Head Start system. (This was considered especially important for migrant families moving upstream with the harvest and enrolling their children in several Head Start programs in a single year.)

- This toolkit should contain a variety of resources and information to assist Head Start program staff in implementing educational and prevention programming for children and their families.

- Although the messages contained in the toolkit should be consistent, the method of delivery and templates provided should be able to be modified for individual tribes, languages, and communities. Use effective health promotion methods such as novellas, promoters, posters, public service announcements, and picture-rich brochures to convey oral health messages.

- Disseminate the toolkit widely within all levels of Early Health Start and Head Start and support efforts for training and technical assistance to promote use of the oral health toolkit.

- Oral health education and prevention programs should be developed in a culturally competent manner with input from Head Start staff as well as parents of AI-AN and Migrant children.

Where professional consensus on oral health topics does exist, MCHB and the HSB can utilize all available communication mechanisms to convey this information to Head Start regional and program staff. In instances where discrepancies exist, MCHB and the HSB can bring leaders together and develop recommendations based on scientific evidence or expert opinions. In addition, both Bureaus can promote opportunities and support efforts for health professional students and clinicians to work in communities, learn about Head Start programs, and provide effective oral health measures that can reduce oral health disparities among pregnant women and preschool-age children. Breakout session participants were hopeful that the final reports emerging from these Forums combined with an increased need by the general public for a consistent oral health message would inspire the health and dental communities to address this challenge. In addition, while discussing curricula and continuing education for health and dental professionals, both Regions felt that health professionals needed specific knowledge, skills, and training to provide culturally competent care to AI-AN and MSFW families and their children.

Also, targeted delivery of these messages was considered especially important. Participants felt that identifying the appropriate decision makers in AI-AN and migrant communities was vital. Tribal leaders were considered important for AI-AN populations although it was noted that "convincing grandma" would have significant impact. For MSFW populations, fathers, crew leaders, and community leaders such as Catholic priests were identified as those who could influence health decisions, while mothers in all families had the greatest impact on meals and preventive health behaviors.

Strategies to address a lack of oral health data collection:

- Head Start families should be included in qualitative research to identify the specific barriers and effective interventions to overcome barriers that AI-AN and Migrant families face in accessing oral health services.

- With appropriate safeguards in place for the health of the children, Head Start programs near dental programs engaged in research could offer to participate in prevention studies.

- Head Start regional offices could provide the infrastructure, advocacy or resources to Head Start programs interested in participating in oral health-related quantitative and qualitative research programs and demonstration projects.

There was broad discussion about the various factors influencing oral health data collection and tracking of oral health needs in Early Head Start and Head Start. Both groups acknowledged the importance of improving the Program Information Report (PIR) process to ensure that oral health-related data is complete and accurate. In addition, they suggested collaborative partnerships between Early Head Start and Head Start programs with Tribes, IHS, Migrant Health Centers, States, and communities to conduct oral health assessments and supplement the PIR data.

The groups discussed the reasons behind limited support for oral health research and demonstration projects that specifically evaluate oral health interventions for pregnant women, infants, and children enrolled in AI-AN and Migrant and Seasonal Head Start programs. Despite significant oral health disparities, these special populations are small in number within the United States and often lack a voice to advocate for funds to conduct health research and demonstration programs.

In light of these recommendations, the HSB and MCHB can encourage research opportunities with these special populations and promote the integration of oral health into research and evaluation activities through HSB- and ACF-supported initiatives and MCHB- and HRSA-funded projects. This can include efforts to set research agendas, support research conferences

and publications. Also, the HSB and MCHB can advocate for inclusion of these population groups into studies and demonstrations as well as collaborate with Federal agencies and foundations (e.g., NIH and NIDCR Health Disparities Research Centers, the IHS, CDC Prevention Research Centers, CMS, the Agency for Healthcare Research and Quality, Delta Dental Washington Dental Service Foundation).

Once sufficient data are collected, information dissemination becomes critical, since participants felt that getting these findings out to Head Start policymakers, regional and program staff was necessary to create change. Regarding the dissemination of research findings, the participants in the breakout groups identified the following requirements: (1) written materials should be in the language spoken by parents and AI-AN or Migrant community decisions makers and at a literacy level that can be comprehended by these stakeholders; (2) data should be presented in a culturally sensitive manner; and (3) evidence on options for oral health education, prevention, early intervention, and clinical care should be presented in order for these populations to make an informed decision.

B. Access to Oral Health Care

1. Issues and Challenges in Access to Oral Health Care

Access to comprehensive dental care, including preventive and restorative services, is crucial to eliminating oral health disparities among pregnant women and young children attending Early Head Start and Head Start programs in Regions XI and XII. The access challenges discussed at both special population forums included **workforce challenges, funding or reimbursement challenges,** and the **barriers inherent in geography or a migrating population**.

Unfortunately, both the IHS and Migrant Health Centers report significant vacancies for dentists and dental hygienists. This overall lack of providers, especially in rural areas (some Alaska Native communities are accessible only by plane during temperate months), is compounded by the lack of community dentists able or willing to accept Medicaid. The

geographic isolation of Head Start programs in rural areas and the lack of available transportation or convenient hours also prevented many families from accessing dental care. In addition, it was noted that IHS dental clinics and Migrant Health Centers with dental programs are not located in all communities with Region XI and XII Head Start programs. In many communities, these federally funded oral health programs lack the capacity to meet the oral health needs of young children and pregnant women.

In addition, some migrant families face the dilemma of being ineligible to receive federally funded health insurance or are fearful of revealing their immigration status to health providers. The combination of poverty and lack of awareness of ways to prevent the oral disease results in many of these families relying exclusively on emergency care. Participants from both Regions commended the Head Start performance standards for mandating oral health screenings but noted significant challenges in obtaining care for those identified as being in need of treatment. In the case of many migrant children, they often are screened upon enrollment in an upstream MSHS program but need to move on before an appointment with a dentist can be scheduled. Action steps related to each of these challenges are discussed in turn in the next section.

2. Strategies for Improving Access to Oral Health Care

Breakout session participants noted that addressing workforce issues requires long-term strategies to recruit and retain public health dentists and dental hygienists willing to serve in the IHS, tribally operated programs, or Migrant Health Centers or locate their dental practices in underserved communities.

Strategies to address workforce challenges:

- Develop and support recruitment strategies that include a skillful combination of incentives and marketing. For example, many participants living in rural areas spoke proudly of their connection to nature or the wilderness and felt that their lifestyle could hold a special appeal for certain providers.

- Balancing the debt of dental school with salaries was understood to be a formidable challenge, so various forms of scholarships and loan forgiveness for dental students and dental hygiene students were discussed by the groups.

- Create incentives to recruit culturally competent providers, perhaps by identifying talented high school students on reservations or from MSFW families. Creating a mechanism for Mexican or Central or South American dentists to be able to provide care in Migrant Health Centers also was suggested as an option.

- If not enough dentists can be enticed to serve these populations, expanding the scope of practice for dental hygienists and increasing the skills of primary care clinicians (e.g., pediatricians, nurses) to provide preventive care for pregnant women and young children enrolled in Early Head Start and Head Start was noted as a possible next step.

Although the discussion groups acknowledged that these strategies were beyond the scope of Head Start Regional offices to provide, they felt that overall workforce issues were especially severe for these populations. They were often unable to access care outside of the Federally-funded programs designed to serve them, and the combined influence of MCHB and the HSB might be brought to bear on this crucial situation.

Strategies to address funding or reimbursement challenges:

- Increase Medicaid reimbursement rates for oral health services; ensure adequate reimbursement for significant travel or case management services and reimburse for services delivered outside a dental office setting.

- Increase funding and incentives for FQHCs and other community-based providers.

- Examine the ethics regarding low or lack of reimbursement for preventive care versus Medicaid reimbursement for dental treatments requiring anesthesia and surgery.

Strategies to address geographic barriers:

- Increase the use of mobile dental programs such as dental vans or portable dental equipment.

- Allow dental hygienists or trained Head Start staff to apply fluoride varnishes. (The Dental Health Aide Program, which is developing new tribal dental program providers in Alaska, was mentioned by Region XII participants.)

- Increase the use of preventive methods such as fluoride varnishes and Xylitol gum for pregnant women and young children.

- Allow Head Start programs to triage limited dental appointments to those children with the greatest need for followup treatment.

C. Cross-Cutting Recommendations

Despite the challenges facing Head Start Programs in Regions XI and XII, participants were energized by the discussion of strategies to address the unmet oral health needs of AI-AN and migrant children and their families. Furthermore, although the two populations have many unique characteristics, participants in the two forums clearly share many perceptions regarding strategies needed to improve the oral health of Head Start children in their regions. These may be summarized by the following broad cross-cutting recommendations which, it is important to note, were also identified as priority areas for attention by the other regional forums. For this reason, these recommendations represent important areas of focus for national attention.

Support the development of unified consistent oral health messages for use by Head Start programs. Dissemination of culturally competent information in the appropriate language and at the appropriate literacy level is needed for Head Start program staff, parents, and children. Providing Head Start programs with a toolkit that includes training guides, brochures, CDs, posters, forms, and consistent oral health messages was considered critical. Encouraging professional health and dental organizations to reach and promote consensus on unified messages regarding tooth brushing, age of first dental visit, and appropriate use of fluorides is a necessary first step. Once these messages and materials are developed, it is necessary to support dissemination as well as training and technical assistance opportunities. It is vital in the long term to stress the importance of oral health and support the integration of oral health into all of the Head Start programs service areas including education, health, disabilities, family and community partnerships, and program management and operation.

Support data collection, applied research, and demonstration programs on the extent of oral health challenges and interventions to improve oral health in Region XI and XII Head Start programs. These efforts should integrate improved ways to track oral health needs in Head Start programs accurately and include oral health in community health assessments. The applied research initiatives can evaluate and demonstrate preventive measures for pregnant women, infants, and children attending Early Head Start and Head Start programs. Qualitative data are needed on strategies to overcome the internal and external obstacles faced by AI-AN and Migrant families in accessing oral health services. Finally, cost-benefit studies would aid decision makers such as tribal leaders to understand the long-term savings of prevention.

Identify ways to recruit and support dental professionals to serve pregnant women and children enrolled in Regions XI and XII Head Start programs. Across the country, dedicated dental professionals find working with AI-AN and migrant populations to be rewarding careers. However, a significant workforce challenge exists if we are to meet the current and future oral health needs of these special populations. Clearly, a long-term solution to this access challenge is needed to eliminate oral health disparities. From these Forums, a number of recommendations emerged, including advocacy on behalf of scholarships and loan forgiveness for dental professionals, increased Medicaid reimbursements, expansion of practice acts, and use of allied professionals. These all should be reviewed and considered as options to address the shortage of providers available in rural and remote areas.

Finally, as time is required to implement these recommendations, it is important to disseminate information to Head Start programs regarding the importance of oral health and its relationship to overall health. A consistent message on the importance of oral health and prevention must be communicated systematically to the Head Start community, including those at the national, regional, State, and local program levels. Electronic and print media can be used as well as communication networks established by the Head Start Technical Assistance System, State Head Start collaboration offices, national Head Start meetings, and MCHB funded Head Start regional oral health consultants. It is only by providing Head Start programs with the

necessary training and resources that the unmet oral health needs of pregnant women and children can be addressed in the future.

III. Conclusion

In 2004, the IAA between the HSB and MCHB was renewed with the goal of enhancing the ability of the two Bureaus to continue to partner on behalf of improved oral health outcomes for pregnant women and children enrolled in Early Head Start and Head Start. The IAA encourages creative partnerships at the national, regional, State, and community levels. The diversity of participants attending these Forums reinforced the importance of future collaborative partnerships across sectors throughout the country to eliminate oral health disparities among AI-ANs and MSFWs. Although the pregnant women and children enrolled in Early Head Start and Head Start programs in Regions XI and XII face unique challenges, there are a number of opportunities that the HSB, MCHB, and other partners can undertake to address this critical health need.