

# Head Start Community Forum

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## Head Start and Community-Based Oral Health Programs: Enhancing Collaborations to Improve Oral Health

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## I. Executive Summary

In 1999, the Office of Head Start (OHS, then the Head Start Bureau), the Health Resources and Services Administration (HRSA), the Centers for Medicare & Medicaid Services (CMS, then the Health Care Financing Administration), and the 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 through increased collaboration at the Federal, State, and local levels to enhance access to oral health services.

One outcome of this National Forum was the formulation of an Intra-Agency Agreement among the OHS, the Administration for Children and Families, and HRSA's Maternal and Child Health Bureau (MCHB) to develop linkages to support oral health in Head Start (HS). As part of this agreement, the Bureaus decided to sponsor regional forums to determine how organizations and agencies could work together to improve the oral health of participants in HS, including a series of forums with professional dental organizations. The success of the 12 regional forums and three professional organization forums conducted between 2001 and 2005 led to additional funds being made available for three additional professional organization forums to be held in 2006. The Hispanic Dental Association held its forum in February followed by a meeting with the American Dental Education Association in June 2006.

The last in this series of forums, the Head Start Community Forum, was held on December 4, 2006 in Washington, DC. Forum participants included leaders from foundations supporting community oral health initiatives and representatives from oral health programs working in community health centers (CHCs) and local health departments (HDs) as well as Federal representatives, including the MCHB and OHS. These participants represented organizations with a demonstrated commitment to addressing community health issues related to oral health and specifically, within Early Head Start/Head Start (EHS/HS) programs.

Forum participants were convened to discuss their experiences collaborating with EHS/HS programs and to identify opportunities for future collaboration. Participants recognized the unique role that each of these groups could play in improving oral health outcomes of MCH populations and identified the following strategies that could be undertaken by foundations, local HDs, and CHCs to promote and implement oral health efforts.

#### Strategies for Foundations:

- Convene stakeholders to discuss issues/topics related to oral health such as disease prevention or oral health systems of care.
- Draft policy papers and statements to advance the adoption of best practices.
- Promote policy discussions on cutting-edge research topics.
- Advocate for policies that may improve access (e.g., increasing Medicaid reimbursement rates, development of dental periodicity schedules) within States and nationally.
- Conduct education and advocacy efforts to integrate oral health into mainstream health discussions and elevate the awareness of oral health issues, especially among legislators.
- Fund demonstration projects that promote the integration of oral health services into broader systems of care and facilitate the development of relationships at the community level.

#### Strategies for Oral Health Programs Based in CHCs and local HDs:

- Convert to a Federally Qualified Health Center (for CHCs that do not have that status) to maximize funding opportunities.
- Increase training opportunities for dental and dental hygiene students and new dental professionals within CHCs and local HDs through residency programs, internships and supervised volunteer programs.
- Promote the expanded workforce opportunities in these clinic settings in CHCs and local HDs among newly graduated dentists, dental hygienists, and dental assistants.
- Explore reimbursement options through Medicaid or the Title V grant for services such as outreach and case management.
- Implement an effective infant oral health program, which in time would create less of a burden on EHS/HS. It would involve educating parents, having children seen by age 1–2 and establishing access to care for kids at risk. HRSA has a collaborative where this model is being applied in Colorado.

- Dedicate time weekly (identifying the specific day) to provide dental care for children in EHS/HS in the clinic settings.
- Give treatment priority to children enrolled in EHS/HS.
- Collaborate with local stakeholders (dental society, EHS/HS, pediatric community, school systems) to develop a community oral health agenda.
- Prioritize the collection of patient data and the tracking of surveillance data.
- Educate community leaders and stakeholders on oral health issues.

A full report can be found on the National Head Start Oral Health Resource Center Web site: <http://www.mchoralhealth.org/HeadStart/index.html>. It is the hope of the MCHB and OHS that this information will also reach a broader audience, particularly those working in foundations, community health centers, and local health departments and encourage them to prioritize the oral health needs of the children enrolled in EHS/HS programs in their communities.

## II. Background on the Forum

In 1999, the Office of Head Start (OHS, then the Head Start Bureau), the Health Resources and Services Administration (HRSA), the Centers for Medicare & Medicaid Services (CMS, then the Health Care Financing Administration), and the 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 through increased collaboration at the Federal, State, and local levels to enhance access to oral health services.

One outcome of this National Forum was the formulation of an Intra-Agency Agreement among the OHS, the Administration for Children and Families (ACF), and HRSA's Maternal and Child Health Bureau (MCHB) to develop linkages to support oral health in Head Start (HS). As part of this agreement, the Bureaus decided to sponsor regional forums to determine how organizations and agencies could work together to improve the oral health of participants in HS, including a series of forums with professional dental organizations. The success of the 12 regional forums and three professional organization forums conducted between 2001 and 2005 led to additional funds being made available for three additional professional organization forums held in 2006. The Hispanic Dental Association held its forum in February followed by a meeting with the American Dental Education Association (ADEA) in June 2006.

The last in this series of forums, the Head Start Community Forum, was held on December 4, 2006 in Washington, DC. The focus of this Forum was the enhancement of collaborations between EHS/HS and community-based oral health programs community-focused foundations, to improve oral health. Forum participants included leadership from foundations supporting community oral health initiatives and representatives from oral health programs working in community health centers (CHCs) and local health departments (HDs) as well as Federal representatives, including the MCHB and the OHS. These participants represented organizations with a demonstrated commitment to

addressing community health issues related to oral health and specifically, within Early Head Start/Head Start (EHS/HS) programs. A planning committee identified participants that had various levels of collaboration with EHS/HS programs and could provide geographic representation from across the country. (Participant list in Appendix B).

Forum participants were convened to discuss their experiences collaborating with EHS/HS programs and to identify opportunities for future collaboration. The day-long forum included presentations in the morning and group discussions in the afternoon. These discussions were facilitated by Jane Steffensen, M.P.H., CHES, Consultant for the Head Start and Oral Health Partnership Project. She has served as a facilitator of past Head Start Forums and provided continuity in this series of forums conducted under previous MCHB contracts.

### **III. Introductions and Opening Remarks**

#### **A. Attendee Introductions**

Forum participants were welcomed by Ms. Steffensen. She then briefly reviewed the day's agenda and the goals of the forum, which included the following:

- Provide Forum participants with an overview of the EHS/HS programs.
- Discuss current perspectives of oral health programs within CHCs and local HDs.
- Review the successes and challenges of collaborations related to oral health education, prevention, and access to clinical services between EHS/HS and oral health programs of CHCs and local HDs.
- Discuss the opportunities that exist for future partnerships between foundations, EHS/HS Programs in collaboration with oral health programs of CHCs and local HDs.
- Outline recommendations for specific actions to disseminate information to foundations, EHS/HS Programs, oral health programs within CHCs and local HDs about successful programs and promising practices that can be replicated in communities.

Participants were then invited to introduce themselves and briefly describe their current and past involvement with the OHS and local EHS/HS Programs.

## B. Overview of the Early Head Start/Head Start Programs

- Robin Brocato, Health Specialist, OHS

Ms. Brocato, Health Specialist with the OHS provided a brief history of the HS program. She noted that HS began in 1965 as a summer program focused on improving the health, nutrition, and cognition of at-risk children ages 3–5 prior to entering kindergarten. In subsequent years additional research supported intervention before the age of 3 and in 1994 the program was expanded to include EHS, a child development program for pregnant women and for children from birth through 3 years of age. Over time what began in the 1960s as a half-day child care service evolved into a full-day, full-year program that has served more than 25 million children. The EHS/HS program is now a comprehensive child development program meeting the health and social service needs children from birth to age 5, pregnant women, and their families.

The HS program consists of 12 regions, which includes the special populations of American Indian and Alaska Natives (Region XI) and Migrant and Seasonal Farmworker families (Region XII). Structurally, the OHS is considered a “demonstration program” which must be reauthorized periodically. Funding bypasses State government and is allocated to organizations at the local level, where support and oversight of HS programs are provided by Regional Offices. This decentralized funding mechanism mandates strict adherence to a set of performance standards that the grantee and delegate agencies must implement specific services in order to receive funding. The requirements include the following:

- Enrollees include pregnant women and children from birth to age 3 (EHS) and children ages 3–5 (HS).
- Families must meet income guidelines according to the HHS Poverty Guidelines (slightly higher income families may be served if space is available) and live in a specific geographic area.
- Children in foster care are eligible regardless of income.
- Families receiving public assistance (Temporary Assistance to Needy Families) are eligible regardless of income.

- At least 10 percent of enrollment opportunities must be offered to children with disabilities.

On certain occasions, eligibility varies, as is the case with Migrant and Seasonal and American Indian-Alaska Native populations.

Ms. Brocato shared some demographic information on the HS population:

- Approximately 35 percent of children are White, 33 percent are Latino, 31 percent are African-American, 5 percent are American Indian, 2 percent are Asian, and 1 percent are Hawaiian and Pacific Islander.
- The majority of the children are 4 years old.
- Almost 1 million children were served during the 2004–2005 program year.

The EHS/HS programs promote school readiness by enhancing the social and cognitive development of children from families with low incomes. This concept supports parents in their role as primary educators of their children as well as supporting a diverse and culturally sensitive learning environment while meeting basic health needs. The program is unique in that it:

- Involves parents in all aspects of decision making
- Encourages parent volunteers and community representatives on the policy council
- Requires community partnering
- Promotes parent hiring.

To guarantee accountability, Federal monitoring processes in place. Each EHS/HS program collects and submits Program Information Reports (PIR) data annually. Additionally, all EHS/HS programs are reviewed using PRISM, a set of standardized instruments and processes used to assess grantees on a regular basis. Currently, HS is using the National Reporting System to track individual performance pre- and post-HS enrollment in order to determine the overall impact of services provided by HS programs.

Ms. Brocato emphasized the comprehensive nature of the services provided to children attending EHS/HS which includes the following:

- Child development and education
- Medical screenings/exams
- Dental exams
- Nutritious meals
- Mental wellness
- Parent education
- Home visits.

Specific to oral health, the EHS/HS program is required to assure that each child is up to date on a schedule of well child health doctors visits, including dental, as determined by the State Early Periodic Screening Diagnosis and Treatment (EPSDT) schedule, within 90 days of entry into the EHS/HS program. There is information suggesting that this performance standard has improved access to both medical and dental care. The OHS has conducted a Head Start Impact Study in which parents report their children have better access to oral health services with these oral health requirements in place.

Ms. Brocato thanked the participants for attending the Forum and looked forward to learning about the collaborative experiences of CHCs and local HDs as well as the opportunities pursued by foundations to expand oral health education, prevention, and access to clinical services among EHS/HS programs.

### **C. MCHB/Head Start Intra-agency Agreement**

- John Rossetti, D.D.S., M.P.H., Oral Health Consultant, MCHB

Dr. Rossetti, former Chief Dental Officer to MCHB and currently an Oral Health Consultant to MCHB and OHS provided background information on the MCHB/HS Intra-agency Agreement (IAA). Dr. Rossetti stated that the overall goal of the IAA between ACF (OHS) and HRSA (MCHB) was to elevate the importance of oral health while utilizing the strengths of the HS program. He reinforced the potential impact of this agreement considering the prevalence of dental disease among EHS/HS children. It is

noteworthy that oral health is the greatest unmet health need among children in EHS/HS and difficulty accessing dental services is a major concern to many grantees.

The IAA established a successful collaboration between the OHS and MCHB. HS benefited from the access to the dental expertise within MCHB. Meanwhile, MCHB was able to link its infrastructure and appropriate contacts directly to this target population. In addition, the IAA has increased the incorporation of oral health into many more MCH funded programs. This agreement has also supported the collaboration activities of State and local agencies and programs.

Over the past 5 years, the IAA has supported both regional and State/Territorial HS Forums convening dental professionals, Medicaid, policy makers and other maternal and child health (MCH) stakeholders committed to improved oral health outcomes for at risk children. These Forums have resulted in recommendations for the integration of oral health into EHS/HS programs and increased access in local communities. Every State and Territory has been funded to hold these HS oral health forums that engage the oral health programs, MCH, and Medicaid agencies to draft and implement action plans. Also, the IAA supported the convening of professional dental organizations including the American Dental Association (ADA), American Academy of Pediatric Dentists (AAPD), and the American Dental Education Association (ADEA) among others to discuss how to integrate EHS/HS into dental practice and dental education programs to further strengthen professional partnerships and improve the oral health of underserved children and families.

Dr. Rossetti noted that the IAA has been successful because of complementary goals shared by HS and MCHB. The OHS has made oral health a priority within its program due to the willingness of MCHB to support oral health activities not necessarily funded through the OHS. The IAA has stimulated the development of partnerships to further the end goal of elevating the oral health needs of the pregnant women and children enrolled in EHS/HS.

## IV. Plenary Presentations

### A. Experiences of Foundations Supporting Community Oral Health Initiatives Focusing on Early Head Start/Head Start Programs

- Tracy Garland, M.U.P., President and CEO, Washington Dental Service Foundation

Ms. Garland began her presentation by sharing the successful approach taken by the Washington Dental Service Foundation (WDSF) to promote oral health by reframing oral health as an important preventive health issue that has consequences in early learning. She discussed the WDSF's attempt to improve the oral health of children and families in EHS/HS through its curriculum, *Cavity Free Kids* (CFK). This curriculum was created to meet existing HS requirements and was developed through a process that incorporated feedback received during parent, teacher, and staff focus groups.

The basic philosophy of CFK has included the following:

- Demonstrate; do not preach. Educate; do not nag.
- Have no guilt – present “new” information in a matter-of-fact style.
- Involve the whole family.
- Have the tools to empower.
- Focus on prevention.

In 2003, WDSF was able to implement pilot testing in Washington State, which also included an expert review and evaluation of this new curriculum. Ms. Garland shared the results from the pilot program:

- Eighty-one percent of piloting HS programs implemented CFK.
- Eighty-seven percent were comfortable in training other colleagues.
- Seventy-eight percent of participants improved their knowledge of oral health.
- Ninety-seven percent stated that the delivery and content of material was excellent.

This piloting resulted in specific educational activities that could be used in the classroom settings as well as in parent meetings. Also developed were staff training materials and a home visitor “tooth kit.” The positive feedback on CFK from families and HS staff has resulted in tentative plans to take this curriculum beyond HS into the mainstream child care systems.

Ms. Garland was able to demonstrate the qualities of the CFK curriculum by having Marina Espinoza, her WSDF colleague, conduct a portion of the classroom lesson with the forum participants. After the brief interactive lesson, participants provided positive feedback and commented on the effectiveness of the message.

After the lesson, Ms. Garland discussed some of the issues faced by HS programs in implementing this curriculum, including budget constraints and the lack of support. She felt that the greatest challenge was due to the high level of staff turnover in HS programs, which is reported as approximately 40 percent annually based on national statistics.

In closing, she left the audience with the lessons learned from this process:

- Model creativity to inspire others.
- Focus groups provide valuable insights.
- Local and State HS ownership is key.
- People tend to support that which they have a hand in creating.
- The need for CFK champions and advocates is ongoing.

## **B. Developing a Community-based Model: Western Dairyland’s Initiative for Head Start Children and Low-income Pregnant Women**

- Kiyoko Fiedler, M.P.A., Director of Planning and Development, Western Dairyland Economic Opportunity Council

Ms. Fiedler shared her experiences as Director of Planning and Development of Western Dairyland Economic Opportunity Council. As a community action agency in western

Wisconsin, Western Dairyland supports community-based programs, including HS within its service area of four predominantly rural counties.

In her management position, Ms. Fiedler assisted the HS program in conducting a needs assessment process about 5 years ago. This process incorporated parental input through the use of extensive focus groups and surveys and involvement of the policy council, which includes parental representation. The needs assessment found that a major problem for the community was the difficulty accessing oral health services.

In response to this finding, Western Dairyland secured a 9-month planning grant from the OHS. The planning group included parental representatives, the only two pediatric dentists in the area, county health departments, the Department of Human Services, and representatives from the dental schools at the University of Minnesota and Marquette University. The planning group developed an oral health treatment and education model and also explored the root causes of limited access to preventive dental treatment and care.

The planning group's comprehensive program *Shining Smiles* addressed the oral health needs of children in HS, their families, and pregnant women eligible for Medicaid by addressing the need for treatment and education as well as identifying the primary goal of creating a dental home<sup>1</sup>, for every HS family (including children in HS, parents, and siblings). Understanding that early intervention is imperative to the prevention of costly treatments at later stages of disease, the education component focuses on pregnant women receiving oral health education and dental services to improve their own oral health at county health departments.

Ms. Fiedler went on to describe the training that is provided to all 70 HS staff working at all levels of the *Shining Smiles* program, including the directors, teachers, and bus

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<sup>1</sup> The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate (AAPD, Council on Clinical Affairs, 2006).

drivers. Using a “Train the Trainer Education Model” Western Dairyland hired a dental hygienist to serve as the Dental Services Project Manager for the program. In this role, the dental hygienist provides preventive services for children in HS and also conducts the training of HS teachers, who in turn conduct trainings with parents of children enrolled in their programs. Children in need of restorative services are transported by the program to dental offices where they receive treatment. There are future plans to equip all four HS centers with portable dental equipment to allow visiting dentists to provide services at the centers.

The planning groups identified additional barriers to care. Ms. Fiedler explained the difficulty of attracting dentists to this rural area, which has led to an insufficient number of dentists available to treat HS children. The group also found that among practicing dentists, few were willing to participate as a Medicaid provider. The dentists in private practice cited several barriers to participating in Medicaid including the low reimbursement rates, onerous paperwork, and high no-show rates among Medicaid patients. Parents identified the lack of transportation and child care and difficulty locating providers that accept Medicaid, as barriers that impeded their ability to obtain needed dental care.

In closing, Ms. Fiedler shared the strategies they have implemented to address some of these barriers. The program works with HS parents to provide education focused on office etiquette and emphasizes the importance of keeping dental appointments. In response to the complaints from dentists regarding the low reimbursement rates and onerous paperwork, Western Dairyland made the decision to become a Medicaid provider and contract with dentists in private practice for their services. In addition, Western Dairyland secured grant funding to augment the reimbursement rates to 125 percent of Medicaid payment rates and also completes the necessary paperwork for dentists. Looking to the future, Ms. Fiedler hopes that their approach will demonstrate to policymakers the impact of increasing reimbursement rates. She also is hopeful that Western Dairyland will be able to provide legislators with data that clearly shows the cost effectiveness of the Shining Smiles model.

## V. Facilitated Discussion Sessions

### A. Group Discussion: A Review of Successes and Challenges of Current Collaborations with Early Head Start/Head Start Programs

Ms. Steffensen opened the afternoon group discussion by soliciting participants to share their successes and challenges in working with EHS/HS programs. Comments shared during the discussion session reflected participants' broad range of experiences working with the programs in their respective communities. Participants discussed a number of successes, including improved access to care through the use of triage models, collaborative practice, and the establishment of dental homes for children. Examples of successes are listed in the next section and organized by the categories of (1) early intervention and prevention, (2) outreach and education, (3) access to care, and (4) data collection.

#### **Early Intervention and Prevention**

- Provided preventive care sooner by identifying someone to champion oral health within a HS center
- Provided preventive dental services, including fluoride varnishes using nurses and other medical professionals

#### **Outreach and Education**

- Educated HS parents and teachers on the importance of oral health care by having them first discuss their own oral health needs and past experiences accessing dental services
- Had bilingual health workers approach pregnant women to provide basic education and to enroll them and future child in an oral health care program
- Incorporated established oral health curriculums into training for HS staff and parent meetings

#### **Access to Care**

- Used a triage model using a dental hygienist to conduct dental screenings at HS centers in order to identify those children in need of dental care
- Expanded the scope of practice for dental hygienists by creating an “advanced dental hygiene practitioner” position. Through this model, a dental hygienist can

enter into a collaborative agreement with a dentist and can provide diagnostic and preventive services to children in HS programs and other specified out-of-office settings. This model also would include the collection of surveillance data and incorporate a referral mechanism, which will be tracked.

- Dedicated a set amount of time weekly to provide education, preventive, and restorative services to children from HS within a Federal Qualified Health Center (FQHC) setting. In this model, children were transported to the FQHC, the lobby of which was set up for classroom instruction, therefore minimizing loss of classroom time.
- Offered services to HS families on days that are accessible to families, such as by providing services on Sundays to Migrant and Seasonal farmworkers
- Focused oral health capacity building efforts on CHCs

### **Data Collection**

- Incorporated the collection of surveillance data for children in HS into the dental screening process
- Improved the tracking of oral health data by expanding the incorporation of secure electronic records systems. In this model, local health departments are improving their surveillance system with technical assistance from the Centers for Disease Control and Prevention.

In addition to these successes participants also identified a number of challenges experienced in the past. Challenges related to access were referenced most often during the discussion session. In addition to the issue of access, these challenges covered many areas and are presented in the categories of (1) education, (2) access to care, (3) financing, (4) policy, and (5) coordination.

### **Education**

- Lack of awareness among dental professionals in private practice of the oral health issues and difficulty accessing care experienced by HS populations and other low-income populations
- Developing education curriculums that are engaging and relevant to families in HS
- Training nondental personnel, such as outreach workers and medical assistants, to conduct education and provide anticipatory guidance

### **Access to Care**

- Meeting the high need for dental care among children in EHS/HS and their families
- Difficulty finding available dentists in private practice and the long waiting lists for dental services at the FQHCs and community health centers
- Establishing a dental home for children within the HS program, to ensure they have an ongoing source of care
- Potential resistance from the State dental associations regarding expanding the scope of practice for dental hygienists
- The reluctance among some general dentists to provide oral health services to preschool-age and school-age children

### **Financing**

- Insufficient reimbursement rates for some dental services, particularly for restorative dental services
- Expanding Medicaid benefits to include greater coverage for oral health services for pregnant women and young children
- Limitation of HS funds available to pay for dental services (e.g., restorative care) for children lacking dental health coverage

### **Policy**

- Early integration of best practices and good ideas into policy development
- Most States' failure to implement dental periodicity schedules comparable to the medical EPSDT periodicity schedules
- Securing the support of legislators for policies impacting oral health access, such as increasing reimbursement rates

### **Coordination**

- Lack of standard language, messages, and forms used across HS centers
- Lack of coordination among various systems of care seeing HS populations and other low-income populations
- Coordination of oral health messages with other early childhood programs, such as the WIC program

## **B. Promising Practices**

In the course of this discussion, participants also identified promising practices to improve the oral health of EHS/HS children and their families. The list of suggestions is compiled in the next section.

Promising practices included:

- Integration of oral health education into primary care education
- Linking oral health with other timely issues, including school readiness and obesity initiatives
- Incorporation of an oral health outreach component (involving community liaisons, promotoras) in early childhood programs
- Formal collaborations (e.g., Memorandum of Understanding, cooperative agreement) between CHCs and HS and Migrant/Seasonal HS programs
- Service learning opportunities for dental hygiene students, dental students, and residents in EHS/HS programs, that include education about the families served
- Training opportunities for dentists within HS programs, possibly for CE credits
- The Access to Baby and Child Dentistry program model, which provides training to participating dentists, emphasizes comprehensive preventive dental care in infants and young children, provides enhanced Medicaid reimbursement rates for participating dentists, and includes an outreach component to coordinate care with families and assure timely services
- Use of teledentistry
- Use of mid-level practitioners to conduct screenings, triage, and provide anticipatory guidance
- FQHC/CHCs dedicating a set amount of time each week to provide dental care to children in EHS/HS
- FQHC/CHCs giving priority to children from EHS/HS for dental appointments

### **C. Group Discussion: Recommendations and Strategies to Promote Collaboration with Early Head Start/Head Start Programs**

After identifying the primary issues impacting collaboration with EHS/HS programs, Ms. Steffensen shifted the focus of the discussion to identifying strategies to promote collaboration efforts with EHS/HS programs. Participants identified strategies that could be undertaken by foundations, local health departments (HD), and CHCs as well as other strategies that were broader in nature. Participants recognized the unique role that each of these groups could play in promoting and implementing oral health efforts.

Table 1 presents strategies that were identified as specific to foundations. Participants noted that foundations could play a unique role as a convener of stakeholders and advancing policy to strengthen the provision of oral health services.

<b>Table 1: Strategies for Foundations</b>
<ul style="list-style-type: none"> <li>▪ Convene stakeholders to discuss issues/topics related to oral health such as disease prevention or oral health systems of care.</li> <li>▪ Draft policy papers and statements to advance the adoption of best practices.</li> <li>▪ Promote policy discussions on cutting-edge research topics.</li> <li>▪ Advocate for policies that may improve access (e.g., increasing Medicaid reimbursement rates, development of dental periodicity schedules) within States and nationally.</li> <li>▪ Conduct education and advocacy efforts to integrate oral health into mainstream health discussions and elevate the awareness of oral health issues, especially among legislators.</li> <li>▪ Fund demonstration projects that promote the integration of oral health services into broader systems of care and facilitate the development of relationships at the community level.</li> </ul>

Participants also discussed the role that oral health programs, both in CHCs and in local HDs, can play to promote oral health. Table 2 shows a list of strategies identified by forum participants.

<b>Table 2: Strategies for Oral Health Programs Based in Community Health Centers and Health Departments</b>
<ul style="list-style-type: none"> <li>▪ Convert to a Federally Qualified Health Center (for CHCs that do not have that status) to maximize funding opportunities.</li> <li>▪ Increase training opportunities for dental and dental hygiene students and new dental professionals within CHCs and local HDs through residency programs, internships and supervised volunteer programs. Promote the expanded workforce opportunities in these clinic settings in CHCs and local HDs among newly graduated dentists, dental hygienists, and dental</li> </ul>

assistants.

- Explore reimbursement options through Medicaid or the Title V grant for services such as outreach and case management.
- Implement an effective infant oral health program, which in time would create less of a burden on EHS/HS. It would involve educating parents, having children seen by age 1–2 and establishing access to care for kids at risk. HRSA has a collaborative where this model is being applied in Colorado.
- Dedicate time weekly (identifying the specific day) to provide dental care for children in EHS/HS in the clinic settings.
- Give treatment priority to children enrolled in EHS/HS.
- Collaborate with local stakeholders (dental society, EHS/HS, pediatric community, school systems) to develop a community oral health agenda.
- Prioritize the collection of patient data and the tracking of surveillance data.
- Educate community leaders and stakeholders on oral health issues.

Beyond the strategies specific to foundations and oral health programs, participants also shared broader suggestions and strategies that participants can consider to promote oral health activities, especially those targeting EHS/HS populations. These are listed in Table 3.

**Table 3: Broader Strategies**

- Stay informed about HS by signing up for the *HS Oral Health Alert*, which is an electronic newsletter that provides a synopsis of oral health initiatives.
- Begin program implementation with prevention efforts and incrementally expand oral health services.
- Establish relationships with local EHS/HS programs
- Connect with MCHB-funded programs (e.g., State Early Childhood Comprehensive Systems Grant, State Oral Health Collaborative Systems Grant) that focus on oral health or incorporate oral health as a priority and often partner with HS.
- Consider partnering with nontypical organizations when forming oral health coalitions (e.g., American Bar Association).
- Mobilize dental providers and advocates to establish dental periodicity schedules in States.

- Increase education efforts targeting policy makers through professional associations including the National Conference of State Legislatures and National Governors Association.
- Promote the increased use of electronic records and the ability to track a child's dental and health history.

## VI. Next Steps and Closing Remarks

In bringing the meeting to a close, Ms. Steffensen welcomed Ms. Brocato and Dr. Rossetti to share their final thoughts on the day-long forum. She also informed participants that a final report describing the day's discussion would be prepared and distributed to participants, with the expectation that they will implement some of the strategies identified throughout the day. Ms. Steffensen noted that the Forum Report will also be posted on the National Head Start Oral Health Resource Center Web site: <http://www.mchoralhealth.org/HeadStart/index.html>. The MCHB and OHS hope that this information will also reach a broader audience, particularly those working in foundations, CHCs, and local HDs and encourage them to prioritize the oral health needs of the children enrolled in EHS/HS programs in their communities.

Ms. Brocato expressed appreciation for the opportunity to participate in the Forum and hear the insights of the foundations, CHCs, and local HDs represented. She found the discussion sessions informative, especially comments that broadened her perspective of community issues. Ms Brocato mentioned the enthusiasm that was conveyed by the participants during the Forum about their involvement with EHS/HS programs and reiterated her appreciation for their continued efforts supporting the goals of HS.

She commented on her experience of preparing the HS guidance on oral health and welcomed feedback from those with dental expertise. She noted that the OHS was soliciting additional clarification on some issues, especially oral health care for pregnant women and the use of fluoride toothpaste for children under age 2. She also requested more information from participants on the role of dental providers and the dental delivery system and stated that this information would be helpful to the OHS as

it conducts monitoring activities with EHS/HS programs. She concluded by sharing her hope that HS programs will develop stronger relationships with community-based foundations, CHCs, Migrant health centers, and local HDs.

Dr. Rossetti referenced the past forums held with professional dental organizations and noted that this forum was unique in that it involved a mixed group of participants representing diverse backgrounds and perspectives. He shared his initial uncertainty of combining foundation and public health perspectives, however upon reflection, he felt that it provided for an informative and very constructive meeting.

He encouraged participants to retain the enthusiasm generated from the day's discussion and to return to their communities and seek out collaborations and partners, especially with their local EHS/HS programs. He also encouraged them to access additional information on best practices on the National Maternal and Child Oral Health Resource Center Web site: <http://www.mchoralhealth.org>.

Dr. Rossetti concluded the meeting by imparting the lessons he has learned through his many years of experience creating and sustaining collaborative partnerships to improve the oral health of underserved children and their families, namely:

- People make things happen.
- Do not take “no” for an answer.
- Continue to follow up.
- Good things happen incrementally.
- Most things happen on the small policy level.

## **Appendix A: Agenda**

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# **HEAD START COMMUNITY FORUM**

## **HEAD START AND COMMUNITY-BASED ORAL HEALTH PROGRAMS: Enhancing Collaborations to Improve Oral Health**



Health Systems Research, An Altarum Company, 1200 18th Street, NW, Washington, DC 20036 • December 4, 2006

## **AGENDA**

The Goals of the Forum are to:

- ❖ Provide Forum participants with an overview of the Early Head Start / Head Start Programs
- ❖ Discuss current perspectives of oral health programs within community health centers and local health departments
- ❖ Discuss experiences of foundations supporting community oral health initiatives focusing on Early Head Start / Head Start Programs
- ❖ Review the successes and challenges of collaborations related to oral health education, prevention, and access to clinical services between Early Head Start / Head Start and Oral Health Programs of Community Health Centers and Local Health Departments
- ❖ Discuss the opportunities that exist for future partnerships between foundations, Early Head Start / Head Start Programs in collaboration with oral health programs of community health centers and local health departments
- ❖ Outline recommendations for specific actions to disseminate information to foundations, Early Head Start / Head Start Programs, Oral Health Programs within Community Health Centers and Local Health Departments about successful programs and promising practices that can be replicated in communities

**Monday**

**December 4, 2006**

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- 8:30 – 9:00 am      Registration and Continental Breakfast**
- 9:00 – 10:00 am    Introductions & Opening Remarks**
- Attendee Introductions**
- ❖ Jane E. M. Steffensen, MPH, Consultant, Head Start and Oral Health Partnership Project
- Overview of the Early Head Start / Head Start Programs**
- ❖ Robin Brocato, Office of Head Start (formerly Head Start Bureau)
- MCHB / Head Start Intra-Agency Agreement**
- ❖ Mark Nehring, DDS, MPH, Chief Dental Officer, Maternal & Child Health Bureau, HRSA
  - ❖ John Rossetti, DDS, MPH  
Oral Health Consultant, Maternal & Child Health Bureau, HRSA
- 10:00 – 10:30 am    Presentations**
- Experiences of Foundations Supporting Community Oral Health Initiatives Focusing on Early Head Start / Head Start Programs**
- ❖ Tracy Garland, President and CEO, Washington Dental Service Foundation
- Developing a Community-Based Model: Western Dairyland's Initiative for Head Start Children and Low-Income Pregnant Women**
- ❖ Kiyoko Fiedler, MPA, Director of Planning and Development, Western Dairyland Economic Opportunity Council
- 10:30 – 10:45 am    Break**
- 10:45 – 12:00 pm    Facilitated Discussion**
- Collaborations between Early Head Start / Head Start Programs and Oral Health Programs in Community Health Centers and Local Health Departments: Successes and challenges in oral health education, prevention, and access to clinical services

- 12:00 – 1:00 pm**      **Working Lunch and Facilitated Discussion**
- Opportunities for future partnerships between foundations, Early Head Start / Head Start Programs in collaboration with Oral Health Programs of Community Health Centers and Local Health Departments
- 1:00 – 1:15 pm**      **Break**
- 1:15 – 2:30 pm**      **Facilitated Group Discussion**
- Recommendations for specific actions to disseminate information about successful programs and promising practices with Early Head Start / Head Start Programs
- Recommended Strategies for:
- ❖ Foundations
  - ❖ Oral Health Programs within Community Health Centers
  - ❖ Oral Health Programs within Local Health Departments
  - ❖ Maternal and Child Health Bureau and Office of Head Start
- 2:30 – 3:30 pm**      **Next Steps and Closing Remarks**

## **Appendix B: Participant List**

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**HEAD START COMMUNITY FORUM**  
**HEAD START AND COMMUNITY-BASED  
ORAL HEALTH PROGRAMS:**  
**Enhancing Collaborations to Improve Oral Health**  
**PARTICIPANT LIST**



Health Systems Research, An Altarum Company, 1200 18th Street, NW, Washington, DC 20036 • December 4, 2006

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